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PROFESSIONAL ROLE ORIENTATIONS OF NURSES

by

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A THESIS
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R. Bryce
Supervisor

V R Nyberg

K L Ward

Date: July 11, 1983

DEDICATION

To my children,

Jason Andrew and Jennifer Ann

ABSTRACT

This study examined the nature of professionalism of nurses employed in one selected hospital. Specifically, it was concerned with determining whether a relationship existed between the professional role orientations of nurses and the following positions they held within the hospital organization: general duty staff nurse, nurse educator and nurse administrator. Further, some of the factors which might be related to the variations in professional role orientations among these three groups of nurses were explored and analyzed.

The design of the study was based on a conceptual framework suggested by Hrynyk (1966). A questionnaire was developed to test the following five dimensions of professional role orientations of nurses: knowledge, service, core-organization, colleague-professional and client-autonomy orientations. The questionnaire was divided into two parts: Part A asked for organizational, personal and professional data; Part B consisted of forty Likert-type statements reflecting Professional role orientations of nurses which the respondents were asked to indicate the degree to which they agreed or disagreed with each statement. Of the 237 questionnaires delivered to the participants, a total of 194 or 81.9% were returned.

The data gathered from the questionnaires were subjected to the following statistical analyses: frequency distributions, factor analysis, analysis of variance and correlation coefficients. Factor analysis results indicated that the forty professional role orientation statements did not load significantly within the five dimensions of professionalism that they were intended to measure, however, the solution on six factors was selected as most appropriate for this study and these factors were subsequently labelled according to the professional role orientations they seemed to measure. These factors included: (1) autonomy, (2) knowledge, (3) colleague-professional, (4) core-organization, (5) service, and (6) public-input orientation factors.

One-way analysis of variance was used to determine significant differences between means of nurses on the professional role orientation factors when these nurses were grouped on the basis of position and personal and professional variables. The results indicated that nurse educators had significantly higher means than either general duty staff nurses and/or nurse administrators on the following three factors: autonomy, colleague-professional and service orientations. Significance differences were not noted on the other four factors.

The results of the one-way analysis of variance and the Pearson product-moment correlations indicated that a certain relationship did exist between the personal and professional characteristics of the nurses and their professional role orientations, particularly in the area of education. Baccalaureate nurses were more highly oriented to ideal professional role orientations than their counterparts prepared at the R.N. diploma level or an R.N. diploma plus an added certificate or diploma. As nurse educators comprised the greatest number of baccalaureate prepared nurses, it was suggested that the differences between means of the three groups of nurses, were for the most part, a reflection of the educational variable.

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CHAPTER I

PURPOSE AND DEFINITION OF TERMS

INTRODUCTION

> The modern nurse is caught in the throes of change. Medicine has increasingly made her into an administrative specialist, while her heritage is that of bedside care for the individual patient. From her leaders she is under pressure to become more professional, while the physician and she herself are apt to doubt her qualifications as a professional. She is a woman who finds herself in a work situation where the most prestigious positions routinely go to men. She ranks low in occupational prestige and financial rewards. All this has been described and documented again and again (Katz, 1969:54).

Although the above quote was written over a decade ago, recent literature on the subject of professionalism in nursing indicates that little has changed. Nursing continues to be almost wholly a woman's occupation in which the majority of the work is performed for salary in various kinds of institutions, the most notably being the hospital (Strauss, 1975:25). Baumgart expresses the view that the nurse's clinical role continues to be in subordination to physicians and administrators who have enormous power in the health care system. She writes:

> Replicating the authority structure of industrial society, where men are the decision makers and women the implementers, the authority structure in health care is designed to make it appear that nurses' actions and

> nurses' contributions to patient care are reactive to physicians' judgments and orders and employers' conceptions of institutional needs and prerogatives (1981:2).

Within the hospital environment, nursing involves three major job functions - teaching, administration and bedside nursing. Although the roles that nurses perform may differ, that is, nurse educator, nurse administrator or general duty staff nurse, the goal of providing safe standards of care for patients appears to be a primary focus for all nurses. The aim of nurse leaders continues to be the development of clinical competence and expertise in meeting the health care problems presented by patients both within hospital treatment centers and the community. In other words, there is a sincere effort on the part of nurse leaders to increase the degree of professionalism among the members of the "nursing profession". Gamer writes:

> The most important and powerful idea in the belief system of nursing is the idea of professionalism. This idea has permeated all levels of nursing (and) ... holds that there is a science of nursing independent of and different from medical science, that is under the control of nurses, and that it can be defined and practiced independently (1979: 108 - 109).

This study furnished some empirical data on the nature of professionalism found among a selected body of nurses who occupy different roles in a hospital organization. A review of the related literature and research on professionalism revealed that an appropriate approach to the investigation of the nature of nurse professionalism would be through the analysis of their professional role orientations. In addition, nursing roles may be identified through the positions nurses hold within that organization.

PURPOSE OF THE STUDY

The major purpose of this study was to determine whether a relationship exists between the professional role orientations of nurses and the positions they occupy in a hospital organization.

The Research

The research involved a study of the nature of nurses' professional role orientations through a comparison of three groups of nurses employed in one selected hospital: general duty staff nurses, nurse educators and nurse administrators. In addition, some of the factors which might be related to the variations in professional role orientations among these nurses were explored and analyzed. Answers were sought to the following questions:

1. What are the relationships between the professional role orientations of nurses and the following positions they hold within the hospital organization: general duty staff nurse, nurse educator and nurse administrator?

2. What are the relationships between the professional role orientations of nurses and their following personal and professional characteristics:
    - (a) number of years employed in present position,
    - (b) clinical area of practice,
    - (c) number of years of nursing experience,
    - (d) number of years of teaching experience,
    - (e) number of years of administrative experience,
    - (f) educational background,
    - (g) age, and
    - (h) sex?

Justification of the Study

Nurses are evaluating their roles within health care organizations, the conditions under which they work and the quality of care provided for patients. At the same time, nurse leaders are expressing the need for increased professionalism among the members of the occupation. The quest for increased professional status among nurses has implications for their relationship with health care organizations, with other health care professionals and with the consumers of health care services.

The study of the professional role orientations of nurses may serve as an indicator of the extent of professionalization in nursing. In addition, it may provide some guidance to those who are striving to achieve the professional goals of nursing. Such goals may include changes in recruitment and educational preparation of nurses, the redesigning of nursing services to promote retention and job-satisfaction among nurses as well as to promote excellence in nursing practice and finally, the evaluation of the roles of professional organizations in meeting the changing needs of the members they serve.

DEFINITION OF TERMS

The following are important terms and their definitions as they were used in this study. Other terms not presented here, are defined as they are introduced in the course of the study.

Profession: An occupation whose incumbents create and explicitly utilize systematically accumulated general knowledge in the solution of problems posed by clientele, either individuals or collectivities (Moore, 1976:54).

Professionalism: An ideology and associated activities that can be found in many and diverse occupational groups whose members aspire to professional status (Vollmer & Mills, 1966:viii).

Professionalization: A dynamic process whereby many occupations can be observed to change certain crucial characteristics in the direction of 'profession' (Vollmer & Mills, 1966:vii-viii).

Role: A cluster of functions that come to be expected of a given class of workers within positions that they typically occupy in the organization or social system in which they work (Benne and Bennis, 1959:196).

Role Orientation: The meaning assigned by a person to the requirements of the position he occupies. It is an internalization of one's own role expectations to the extent that they become determinants for action (Hrynyk, 1966:48).

Professional Role Orientation: The cognitive determinants of an individual governing tendencies to action which results in professional behavior (Hrynyk, 1966:36 and 49).

Role Conflict: Conflict which occurs when one is required to fill simultaneously two or more roles that present inconsistent, contradictory or even mutually exclusive expectations (Getzels & Guba, 1954:164).

Position: A place of employment occupied by a person within an organization.

General Duty Staff Nurse: A nurse who carries out functions directly related to patient care on a unit by virtue of her position within the hospital organization.

Nurse Educator: A nurse who teaches nursing students in a nursing program or a nurse whose primary responsibility is to teach other nurses by virtue of her position within the hospital setting.

Nurse Administrator: A nurse who has the authority and responsibility for overseeing and directing the work of others by virtue of her position in the hospital organization. These nurses are often called supervisors or unit supervisors. The former directs the operation of several units; the latter directs the operation of one unit (Douglass & Bevis, 1979:43).

ORGANIZATION OF THE THESIS

This chapter contained an introduction to the study. It also presented the problem statement, the justification of the study and the definition of terms as they were used in the study.

Chapter II presents a review of the theoretical concepts and related literature and research on professionalism. This is followed by Chapter III which contains the discussion of the research methodology.

Chapter IV describes the characteristics of the respondents and presents the analysis of the data gathered from the questionnaire.

The final chapter provides a summary of the major findings of the study. As well, it contains the implications and suggestions for further research.

CHAPTER II

THEORETICAL BACKGROUND AND REVIEW OF RELATED LITERATURE

In this chapter, a review of the literature related to the theoretical concepts of professionalism, role orientation and role conflict is presented. Following this, the literature on professionalism as it relates to nursing as an occupation and nursing practice within a hospital setting is explored. The chapter concludes with a conceptual framework for the study.

THEORETICAL BACKGROUND

This section of the study presents a discussion on the definition of profession and professionalism. A model of professionalism is discussed which provides the basis for questions under investigation in this study. A review of the literature pertaining to role, role orientation and professional role orientation is presented. Finally, role conflict as it relates to professional versus bureaucratic orientation is explored.

Profession

Many academic scholars have devoted uncountable hours to the definition and characterization of profession. Cogan

(1953) states that "no broad acceptance of any 'authoritative' definition (of profession) has been observed." (Monnig, 1978:36). Stinson, in her study "Deprofessionalization in Nursing" presents a wide array of definitions gleaned from the literature and concludes that "the only factor common to all is their eulogistic flavor" (1969:18).

Examination of the literature does reveal that the occupation of medicine provides the model for the definitions of profession. Strauss notes that "medicine is usually considered the prototype of the professions, the one upon which current sociological conceptions of professions tend to be based" (1975:11). Thus, there appears to be a scale for occupational typology with the profession of medicine at its very peak.

Although there are several ways to approach the definition of profession, they all generally contain two core characteristics identified by Goode (1960): "a prolonged specialized training in a body of abstract knowledge and a collectivity of service orientation" (Wolinsky, 1980:258). Moore identifies professions as a subset of a larger occupational class known as services. He therefore defines a profession as "an occupation whose incumbents create an explicitly utilized systematically accumulated general knowledge in the solution of problems posed by clientele, either individuals or collectivities" (1976:54).

Friedson, in his discussion on the meaning of profession, argues that there are two meanings to the word: on the one hand it represents a special kind of occupation, and on the other it represents an avowal or promise. He views a professional as "that type of individual who carries out the duties of his or her profession in a manner befitting the avowed promise of that profession" (Wolinsky, 1980:258-259). He further defines a profession as "an occupation that has achieved autonomy or self-direction" and that this autonomy is granted by society in recognition of the occupation's accomplishments and advances in meeting its avowed promise of the profession (Wolinsky, 1980:259).

Professionalism

There are as many varied definitions of professionalism as there are definitions of the term profession. Various people, over the years, have identified and emphasized different facets of behavior as professional. Hrynyk, in his dissertation "Correlates of Professional Role Orientation in Teaching," states that "in all of the different definitions there are no basic contradictions. There are only variations in what is stressed and in what is included or omitted" (1966:21).

Vollmer and Mills define professionalism as "referring to an ideology and associated activities that can be found in many and diverse occupational groups whose members aspire to professional status" (1966:viii).

Greenwood identifies five common attributes which distinguish professional occupations from non-professional ones. "Succinctly put, all professions seem to possess: (1) systematic theory, (2) authority, (3) community sanction, (4) ethical codes, (5) a culture" (1972:3).

Moore maintains that professionalism should be properly regarded as a scale rather than a cluster of attributes because attributes commonly selected as typifying a profession have differing values (1976:5). He identifies a number of characteristics and places them on a "scale of professionalism" where one attribute is usually present for admission to a higher rank on the scale. They are briefly as follows:

> (1) The profession is a full-time occupation, which comprises the principal source of earned income;
>
> (2) There is present a commitment to a calling, that is, there is an enduring set of normative and behavioral expectations for its practitioners;
>
> (3) There is a formalized organization in which the participants share a common commitment to protect and enhance its interests;
>
> (4) There is a possession of an esoteric body of knowledge based on specialized training or education of exceptional duration and perhaps of exceptional difficulty;
>
> (5) The practitioners exhibit a strong sense of service orientation, that is, they perceive the needs of individuals or collective clients that are relevant to their competence and attend to those needs by competent performance;
>
> (6) Finally, the practitioners proceed by their own judgment and authority, thus

> enjoying autonomy of performance
> (1976:5-6).

For the purposes of his study on professionalization, Hall examined the "professional model" and hypothesized that there are two sides to professionalism: a structural side consisting of four major attributes and an attitudinal side consisting of five components of professionalism. Based on the work of Wilensky, Hall includes the following attributes as being structural in nature: a full-time occupation, an established training school, the existence of professional associations and the formation of a code of ethics (1968:92-93). The attitudinal attributes of professionalism are a reflection of the manner in which the practitioners view their work. The assumption is that the attitudes held by the practitioners demonstrate the degree of professionalism characteristic of the occupation. Hall's attitudinal attributes include: the use of the professional organizations as a major reference (this involves both the formal organization and the informal colleague groupings), a belief in service to the public, belief in self-regulation or colleague control, a sense of calling to the field and finally, a feeling of autonomy (1968:93). Hall stresses that this last attribute, autonomy, is both structural and attitudinal in nature.

> While the structural aspect of autonomy is indirectly subsumed under the efforts of professional associations to exclude the unqualified and to provide for the legal right to practice, autonomy is also part of the work setting wherein the professional is expected to utilize his judgment and will expect that

> only other professionals will be competent to question this judgment. The autonomy attribute also contains an attitudinal dimension: the belief of the professional that he is free to exercise this type of judgment and decision making (1968:93).

Similarly, Hrynyk, devised an "ideal" professional model based upon the most common dimensions included in various definitions of professionalism. His model consists of five basic dimensions which include: knowledge-skill dimension, service dimension, core-organization dimension, colleague-professional dimension and a client-autonomy dimension. He defines these dimensions as follows:

> 1. Knowledge dimension. The work performed by a professional person is essentially intellectual in character and is based on an esoteric, theoretical body of knowledge. It is directed at the unique solution of problems of others. The required skills, based on the application of this knowledge, are normally acquired through a long period of training at the university. There is usually some form of formal testing and licensing procedure at the end of the training period. It is understood that the professional has a responsibility to maintain his competence and to contribute to the extension of the body of knowledge on which his practice is based.
>
> 2. Service dimension. The dimension is characterized by a claim, early in the development of a profession, to a unique mission in society. The profession offers a unique and indispensable public service, always giving the best impartial service to society. The service, pursued with a sense of mission, is often viewed as being of the type which is essential to the survival of a society. A member of a profession is altruistically oriented and is committed to the occupation as a life-time career. He commits himself to provide service whenever the need arises and whatever the circumstances. It should be noted that he may view this societal service as being made

either through the application of his practice to the individuals of society, or through the changes which can be wrought in society by his service.

3. Core-organization dimension. In the process of establishing itself it is apparently inevitable that the profession will organize, but the 'organization' should not be confused with the 'profession.' The organization becomes the enforcer of standards of conduct, codes of ethics and attempts to control licensure and admittance to the profession. Outwardly it contends that its sole purpose is to protect society from the unscrupulous who may attempt to practice the occupation, but actually, it may protect practitioners to at least an equal degree from the interference of society. The organization speaks for the profession and provides opportunities for the growth of circles of colleagueship. Ranking and evaluation within the profession are in the hands of the organization, giving it power over its members. Codes of ethics describe appropriate behavior with respect to the greater society, fellow practitioners, unauthorized practitioners and clients. The organization serves as the core around which professionalism advances.

4. Colleague-professional dimension. The notion of colleagueship stresses the occupational unity of the practitioners in a profession. Strong identification and affiliation with the profession leads to a concern about who one's colleagues are. The 'brotherhood' aspects of colleagueship contribute to the social status and exclusiveness of the professions. Common interests lead to a group loyalty and loyalty of one practitioner to another not ordinarily found in other occupational groups.

5. Client-autonomy dimension. This dimension of professionalism is characterized by the fact that members of a profession become involved in sets of relationships with their clients which do not appear to be duplicated in other occupational groups. The professional applies his unique skills which require the use of individual judgment and discretion. This involves him in fiduciary relationships of trust and faith, placing a

> responsibility on him that leads him to demand autonomy in decisions related to the practice of his profession. Such autonomy in turn places power over the client in the hands of the professional. The client is usually not able to judge the competence of the decisions or of the practice of the professional, but is in the position of needing a service which he is unable to obtain elsewhere. Hence, a trusting society provides the legal and social sanction for the professionals' practice. The client, being unable to place a value on the professional's service usually agrees to pay a fee or fixed charge for it. Changes in the organization of the provision of professionals' services are rapidly producing changes in the ways in which professionals are reimbursed for their work (1966:22-25).

In explaining the use of the model to determine the correlates of professional role orientation in teaching, Hrynyk states:

> The members of a profession may be thought of as a collectivity holding the required norms, values or beliefs, in a manner that is unique to the occupation. Such unique behavior is recognized by their colleagues and by society as 'professional behavior'. The dimensions ... are sub-categories of the general ideology called professionalism ... The personal meanings which an individual member of an occupational group assigns to these dimensions may be thought of as his orientations toward them (1966:20-21).

Hrynyk qualifies his model by asserting that "no present-day occupation has the total 'ideal' orientation towards all five dimensions, but all occupations hold some degree of attitudes related to them. It also appears that different groups within a single occupation may vary in their orientations towards these dimensions" (1966:31-32). The author further states that variations in orientation of various groups within an occupation may be an indication of the professionalization process in operation (1966:32). Further discussion of Hrynyk's 'ideal' professional model occurs later in this chapter as it served as a basis for the questions under investigation in this study.

Role and Role Orientation

Role theory provides a useful conceptual framework for the study of individual behavior within an organization. It deals with patterns of behavior and the ideas which are held regarding these patterns by the participants. Biddle and Thomas (1966) note that the term role has been used to denote "prescription, description, evaluation and action." It refers to "overt and covert processes" and, in addition, refers to "behavior of self and others or to the behavior an individual initiates versus that which is directed toward him" (Riggin, 1982:66).

Benne & Bennis define role as a "cluster of functions that come to be expected of a given class of workers within positions that they typically occupy in the organization or social system in which they work" (1959:196). Scott (1970) refers to role as "a set of shared expectations focused upon a particular position; these expectations include the beliefs about goals or values the position incumbent is to pursue and the norms that will govern his behavior" (Riggin, 1982:66).

Shmalenberg and Kramer, based on the work of Linton and Levinson, identify three essential elements to the conceptual framework provided by the work "role". First, there are structurally-given demands (also called norms, expectations, taboos and responsibilities) that are associated with a given social position. Second, there is the person's conception of or orientation to the part he or she is to play in an organization. And third, there are the actions performed by the people who are in the role. These three elements are commonly referred to as role expectations, role conception and role behavior (1979:204).

It is an arduous but not impossible task to study the overt behavior of individuals in the various roles they perform in a given organization. A much more workable method is to study the cognitive orientations or the person's conceptions of the roles they occupy. Hrynyk likens role orientation to "attitude". He defines attitude as "an organized and consistent manner of thinking, feeling and reacting with regard to people, groups, social issues or more generally, any event in one's environment" (1966:35). Quoting the work of Smith, Brunner and White (1960), Hrynyk views orientation as being more than attitude. Orientations are "tendencies to or determinants of" action; "the sum total of all an individual's orientations is his background for active behavior (1966:33).

Professional Role Orientation

Professional role orientation may be thought of as the "cognitive determinants" of an individual's "professional behavior" (Hrynyk, 1966:36). This implies that members of a profession have certain cognitions respecting the ideology of professionalism and its dimensions as they relate to practice. These cognitions influence and actually determine tendencies to action. As Hrynyk points out, these cognitions do not determine action but determine tendencies to action "since final action may be the result of the interaction of other role orientations with the professional role orientation. For example, there is considerable evidence to suggest that 'organizational role orientation' is an important factor in determining final overt behavior. This interaction of role orientations has been referred to as a 'role system'"(1966:36-37).

Role Conflict: Professional versus Bureaucratic

The role expectations one holds or verbalizes reflect the holder's conception or orientation to the role. Schmalenberg and Kramer state that role expectations both guide a person's actions and provide meaning and explanation to the behavior we see that person perform (1979:204). Role conflict can occur when one is required to "fill simultaneously two or more roles that present inconsistent, contradictory or even mutually exclusive expectations" (Getzels and Guba, 1954:164).

There has been a great deal of theory and research on the topic of role conflict particularly in the social sciences. Research has shown that role conflict emerges when professional workers are employed in bureaucratic organizations (Corwin, 1961; Scott, 1966; Vollmer and Mills, 1966; Hall, 1968; Pavalko, 1971).

Vollmer and Mills (1966) note that the professional who works in formal organizations is subject to the evaluation and control of other individuals who are not necessarily members of his professional group. "This provides the basis for a considerable degree of role conflict when professional individuals become salaried employees in complex organizations - or conversely, when certain categories of employees in bureaucratized organizations become more professionalized" (1966:265).

As recently as 1982, Riggin writes: "role conflict surfaces more frequently when there is a noted difference between one's educational preparation and the bureaucratic or administrative constraints that militate against utilization of the knowledge, skills, values and expectations that one holds for oneself as a professional" (1982:70). Hoy and Miskel (1978) state that professionals and semi-professionals employed in formal organizations bring into focus a basic conflict between a professional orientation and a bureaucratic orientation.

> Although there are many similarities between professional and bureaucratic principles, the potential for conflict remains. Both the bureaucrat and the professional are expected to have technical expertise in specialized areas, to maintain an objective perspective, and to act impersonally and impartially. Professionals, however, are expected to act in the best interests of their clients, while bureaucrats are expected to act in the best

> interests of the organization ... a fundamental source of conflict (emerges) from the system of social control used by bureaucracies and the profession. Professionals attempt to control themselves. They have been taught to internalize a code of ethics that guide their activities and this code of behavior is supported by colleagues ... On the other hand, control in bureaucratic organizations is not in the hands of the colleague group; discipline is based upon one major line of authority ... Herein lies the major source of conflict between the organization and the profession; it is the conflict between 'professional expertise and autonomy' and 'bureaucratic discipline and control (Hoy and Miskel, (1978:71-72).

Hall, in his study on "Professionalization and Bureaucratization" stresses the need to exercise caution in assuming that there is an inherent or pervading conflict between professions and organizations. He points out that there is a variation in both the pervasiveness of professional attitudes and the degree of bureaucratization found in different types of organizations (1968:293). Pavalko explains that as professionals come to be employed more frequently by organizations and as organizations become more dependent upon professional expertise, an adaptation process emerges whereby professionals adapt to employment in bureaucratic organizations and organizations learn to accommodate professionals (1972:250).

Gouldner's (1958) well known study of a small liberal arts college provides supportive research of an individual's adaptation to the conflict between professional and bureaucratic orientations. He identifies two latent organizational attitudes that provide a basis for accommodating such conflict: cosmopolitans and locals.

> Cosmopolitans are those individuals 'low on loyalty to the employing organization, high on commitment to specialized role skills, and likely to use an outer reference group.' Locals are those individuals 'high on loyalty to the employing organization, low on commitment to specialized role skills, and likely to use an inner reference group' (Hoy and Miskel, 1978:73).

Addressing the issue of accommodations to bureaucratic and professional conflict, Hoy and Miskel suggest that in an attempt to alleviate the conflict, professionals working within formal organizations may develop role orientations or attitudes that facilitate adjustment to the bureaucratic demands.

> Some professionals retain a high commitment to professional skills and develop an orientation to reference groups outside the organization, that is, they maintain a strong professional orientation ... Other professionals may become less committed to professional skills and develop an orientation to a particular organization; they are more interested in approval from administrative superiors within the organizations than from professional colleagues outside - a bureaucratic orientation therefore develops. Either of these orientations may be functional: if future personal goals involve an administrative position, a bureaucratic orientation may be functional; if advancement within the profession is desired, a professional orientation may be functional (1978:72-73).

Summary

This section of the study presented a discussion on the theoretical concepts of profession and professionalism. An "ideal" professional model based upon the most common dimensions of professionalism was presented which provided the basis for questions under investigation in this study. Pertinent literature on role, role orientation and professional role orientation was reviewed. It was noted that the professional role orientation of an individual provides the "cognitive determinants" for "tendencies to action" which results in the individual's professional behavior. Finally, the theory of role conflict as it relates to professional versus bureaucratic orientations was explored. It was found that role conflict occurs most frequently when professionals are employed in bureaucratic organizations. However, an accommodation process emerges whereby professionals adapt to employment in bureaucratic organizations and organizations learn to accommodate professionals.

REVIEW OF RELATED LITERATURE AND RESEARCH

Recent nursing literature reveals an increased effort on the part of nurse leaders to facilitate the process of professionalization, particularly in the areas of theory and research and autonomy of practice. In addition, conditions surrounding nursing practice, especially in hospital organizations, are being reviewed and analyzed in terms of their effects on the practice of nursing and the quest for increased professional status.

The following section presents a review of the related literature and research on professionalism in nursing. Aspects of role conflict in hospital nursing are explored as well as a brief review of the current problems and issues facing hospitals and nurses employed within them.

Nursing as a Profession

Katz presents a poignant comment in his discussion entitled "Nurses" when he states: "few professionals talk as much about being professionals as those whose professional stature is in doubt. Nursing leaders, especially those in university schools of nursing, talk a great deal about being professionals" (1969:71-72).

The status of nursing as a profession, has long been a source of controversy and debate. Gamer writes: "nurses have enjoyed the title of professional, as much from courtesy as tradition, but few would claim full professional status for nursing, although asserting the potential for it" (1979:108). Monnig believes that nursing possesses the following "earmarks" of a profession: specialized skill requiring training, success measured by quality of service, a professional association to maintain and improve service and a code of ethics (1978:36-37). Jaycox, in a paper presented to the International Council of Nurses, identifies three commonly accepted criteria of a profession: a long period of specialized education, a service orientation, professional autonomy or self-regulation and control over functions in the work setting. Of these, she believes that nursing has focused on two of these components, service and education and has neglected the area of autonomy (1977:6-7).

Katz considers nursing to be a semi-profession for two major reasons: the caste-like relationship of nurses to physicians and the lack of guardianship over a distinct body of knowledge. If nursing is to develop into a full-fledged profession, Katz believes that "its corpus of knowledge, eg., behavioral knowledge relevant to the care of patients, must be greatly refined and organized and nurses' caste-like status separation with physicians must give way to the colleagueship that now prevails among the various medical specialties" (1969:75-76).

Addressing the issue of the status of nurses as professionals, Murphy offers this reflection:

> Nightingale, who was the 'visionary founder of professional, scientific nursing' ... recognized the meager state of knowledge regarding nursing practice during her time, but envisioned the accumulation of inordinate amounts of knowledge by nurses in the future, which would increase the well-being of humanity and relieve human suffering ... Little evidence exists to show that nursing care has made a significant impact on the general welfare and well-being of society. Moreover, there is little agreement concerning the nature and scope of nursing knowledge, and this at a time when a knowledge explosion is occurring in many other fields (1978:3-4).

The following is Murphy's analysis of contemporary professional nursing:

> The service orientation of nurses seems to have shifted from the welfare of patients to

> the welfare of the employing institution; documentation of the scientific basis for nursing practice is fragmentary; and the autonomy of professional nurses is continually challenged since the knowledge base of nursing has been derived intuitively and experientially. Moreover, some professional nurses have been reluctant to assume the accountability for their profession, which is essential for professional autonomy (1978:4).

The Process of Professionalization in Nursing

Regardless of the present status of nursing as a profession, it is apparent that there is a sincere effort on the part of nurse leaders today to increase the professional status of the members and in so doing to strive for the rewards and prestige that accompany such increased status. Various authors both within and outside nursing have recognized certain features of the occupation which may impede the process of professionalization. Strauss identifies a number of structural features of nursing which are, in total, unlike any other occupation. Briefly put, they are the following: First, nursing is almost wholly a woman's occupation that is massive in scope. Second, it is predominantly and increasingly a salaried occupation. Third, recruitment is relatively open. Fourth, there is a high degree of geographic mobility of nurses and resultant transferability of skills. Fifth, nursing work occurs mainly in three or four types of establishments (namely hospitals, public health agencies, private homes and physicians' offices) where there is a strong tendency to be controlled by the medical profession. Sixth, specialization of nursing tends both to follow hierarchial lines of hospitals or agencies and the clinical specialization of medicine itself. Seventh, there is a strain between education and nursing service based on increased career specialization. Finally, there is a melange of educational institutions, nursing programs and resultant nursing degrees (1975:25-27).

The nursing literature is replete with articles addressing the various conditions which must be changed in order for nursing to claim a higher rung on the status hierarchy. The following discussion highlights the conditions which various authors perceive as being of utmost importance. Dachelet notes that the factors influencing nursing's bid for increased status tend to be described as if independent elements. In reality, they are closely intertwined and tend to reinforce one another (1978:24).

The physician-nurse conflict, sometimes referred to as the doctor-nurse game, has been documented by a number of authors (Babich, 1968; Katz, 1969; Smoyak, 1974; Kushner, 1974; Kalish and Kalish, 1977; Dachelet, 1978; Bush and Kjervik, 1979; Wolinsky, 1980). According to Kalish and Kalish, "the predominate pattern of behavior between physician and nurse has been dominance by the former and deference by the latter" (1977:51). The physician as a consequence of his training and nature of his work, has "long insisted on maintaining the dominant role in the health care scene". He regards other health care professionals as "mainly serving him in so-called captain of the ship role rather than the whole team working side by side serving the patient." Further, physicians seem to place little value on nurses' contributions to patient care and often equate good nursing care with "fulfillment of physicians' demands" (1977:52-53). Nurses, for a number of reasons, the most notably being the socialization process, have assumed a docile, submissive and subservient role in relation to physicians. A study conducted by Duff and Hollingshead (1966) led to the conclusion that "the nurse's desire to gain gratitude, praise and approval from the physician supersedes at times her need to be a competent professional in her own right" (Kalish and Kalish, (1977:53). Remarking on the relationship between nurse and physician, Babich calls for a more instrumental role for nurses: "for it is only by the nurse's assumption of this instrumental role that the ultimate goal can be reached: a medical team on which all members have equal authority regarding patient care from the standpoint of their own discipline" (1968:17). Similarly, Smoyak (1974) expresses the need for "nurse-physician equality" and claims that there is a distinction between medical care (as provided by physicians) and health care (as provided by nurses). Quoting from Dachelet:

> ... medicine and nursing are two separate, distinct professions each with an equally valuable skill to offer and each sharing a common goal. Nursing is emphasizing its expertise in 'caring, comforting, counselling, and helping patients and families to cope with

> their health care problems.' Physician's expertise is acknowledged in diagnosing illness and curing disease (1978:23).

Kushner, in her article "The Nursing Profession: Condition Critical," concludes "efforts to make nursing separate but equal to doctoring will not only raise the nurse's status, but will ultimately improve patient care" (1974:6).

A second major obstacle to the professionalization of nursing is the fact that "98 percent of all active and practicing nurses are women" (Wolinsky, 1980:327) and moreover, the status of nursing is "inextricably bound to the status of women" (Dachelet, 1978:31). Kalish and Kalish state that society has until recently, valued marriage and motherhood for females above any other vocation and nurses, being women, have also valued these goals above their profession. "Nurses have not been career orientated, and most often consider their work as secondary" (1977:54-55). Dachelet notes that "an important consequence of nursing's predominantly female image is that the professional is excluded from policy and decision-making roles - roles society reserves for males. Baumgart believes that if nurses are to have a stronger voice in determining their own destiny and shaping the direction of health services, they must consciously move to understanding and using power (1981:1). Dachelet echoes a similar thought:

> The informal communication networks that lead to power positions and the techniques of maneuvering for power are too frequently not understood by nursing's leadership. If nursing is to increase its status, it must not

> only understand the intricacies of power, but it must aggressively exercise that power to its advantage in a system which equates power with prestige (1978:32-33).

Lamb suggests a few actions that might be taken to bring women and nursing into the mainstream of policy and decision making. Nursing leaders and educators must: first, encourage women to view nursing as a life-time career; second, encourage a stronger community involvement particularly in positions in community health agencies, boards, commissions and citizens advisory groups involved with health issues; and third, encourage nurses to write and introduce legislation at all levels of government and run for elected office where policy decisions are made (1974:5-8).

Intertwined with the problem of nursing as being predominantly a female occupation is the public's image of nursing. As Dachelet so aptly puts it: "the public's perception seems generally to be that anyone, or at least any female, can provide basic nursing service" (1978:28). The perception arises from the nature of nurses' work, that is, "caring, comforting and facilitating." In other words, psychosocial care is elusive in terms of measurement and is not viewed as actively doing something to the patient. "It is ironic but quite possible that to the extent the nurse is effective as a nurse the profession will be accorded less prestige" (1978:30).

A third and final factor impeding nursing's bid for increased professional status encompasses the educational and socialization processes of nurses. As mentioned earlier, there is a confusing number of educational institutions and nursing programs, from the traditional hospital-based diploma programs to the associate degree programs to the baccalaureate and masters level programs within universities. Dachelet refers to the "schism between 'technical' and 'professional' nursing as an internally devisive element in the nursing profession". She argues that this "wide range in educational background, occupational commitment and skill level represented among nurses is largely responsible for the lack of goal consensus in nursing" (1978:27). Christman believes that nursing is "victimized" by this lack of standardization and one of the first steps that should be taken is to resolve the dilemma over basic preparation for Registered Nurse licensure (1978:3). A study commissioned by the Minister of Advanced Education and Manpower (1975) attempted to do just this in Alberta. The Report of the Alberta Task Force on Nursing Education distinguished two levels of nursing education: "one for the preparation of professional personnel, the other for the preparation of para-professional (technical) personnel (1975:113). The committee's recommendations included that "by 1985 there be two routes to professional nursing preparation: (1) a university-based baccalaureate program and (2) an articulated baccalaureate program between a non-university setting and a university setting (and) by 1990 the minimum educational preparation for professional nursing be the baccalaureate (degree)" (1975:114). Needless to say, these recommendations stirred deep feelings among health care groups including employers, educators and various nursing groups. Opposition ran high against both recommendations, the major issues being "the proposal to eliminate diploma nurses" and the "relevance of university-based education to the work of general duty nurses in hospitals" (1978:6-7). The dilemma facing nursing education is yet to be resolved, however, as recently as 1982, Rector, in her discussion of educational preparation for professional practice maintains that "given the rapid growth in knowledge and the complexities of the current health care field, anything less than baccalaureate preparation for professional nurses is unsound and puts nurses in a noncompetitive position with other health care providers" (1982:267). Similarly, Partridge believes that multiple entry points into nursing must be eliminated.

> Credibility will forever elude us as long as we maintain a system whereby education of two, three, four or five years' duration prepares one for a beginning position as a professional nurse. Given the growing complexity of health care and nursing ... nothing less than four years of college - perhaps even more, ideally - will suffice to give students basic professional education (1978:359-360).

A factor subsumed under the educational process and which deserves mention is the nature of the teaching-learning process itself. Christman believes that behavior modeling is vitally important in role socialization into a clinical profession.

> In nursing, most students have to copy their behaviors from lesser prepared nurses because they are unable to study and emulate their teachers ... Nurse faculty members should be expected to enact the full professional role of service, education, consultation, and research similarly to the combinations that are expected of any profession. The merging of education and service as a unity would provide the broad base that is necessary to supply freedom needed to fully develop expertness. Just as long as nurse faculty members continue to abstain from having daily influence on the development of the clinical quality of the nursing practice of the agencies their students use, then just so long will there be a very considerable lag in the development of general excellence in the profession (1978:4).

Schlotfeldt admonishes nurse-teachers for being overconcerned with quantity and less concerned with the quality of nursing personnel. She writes: "nurse educators still lament about the poor quality of practice exemplified in clinical learning environments, while they continue to grind out large numbers of students who learn poor practices from the models they emulate in those learning laboratories." Further, nurse educators rarely "act to improve those practice settings" or to "restrict student admissions when inadequate numbers of qualified faculty are available to teach them" (1974:22-24).

The discussion on conditions influencing nursing's bid for increased status would not be complete without a brief look at changes which are occurring both within and outside the occupation that are enhancing the professionalization process. These changes are outlined below:

Nursing Education. As a consequence of the Report of the Alberta Task Force on Nursing Education, the focus of nursing has shifted from hospital diploma schools to preference for associate and baccalaureate degree programs. Wolinsky states that as baccalaureate programs become more popular, nursing education is becoming a longer process and, as a result, society will begin to confer higher social status on nursing than ever before (1980:328). Dachelet notes that "the enrollment trend in masters and doctoral programs in nursing has been upward over the past decade." In addition, "the quality of the education the nurse is receiving is also increasing. Scholarship, decision-making, and scientific inquiry are no longer unpopular" (1978:33). Although Dachelet is describing the American scene, the writer is confident that these same changes are occurring in Canada.

Research in Nursing. Coupled with the higher quality of education is the trend toward more research into the science of the practice of nursing. Wolinsky notes that as baccalaureate schools of nursing are coming more into vogue, so are graduate schools of nursing which emphasize research as an integral part of their program.

> When these graduate nurses go out to practice, their training in nursing research goes with them and is dispersed to their co-workers. The end result is that nursing education is changing from the technique-only perspective to a scientific inquiry perspective in which nurses seek to scientifically expand their knowledge (1980:328).

Society's Appreciation of Nursing's Contributions. There is a trend in nursing to move toward centers providing primary and secondary health care. As a result, the public is gaining a better appreciation for what nurses do. These centers include " community health centers, health maintenance organizations, family planning clinics and community health centers" - centers which focus on nursing care, that is, "preventive care, health education, health counselling, well baby care and supportive care" (1978:34). Dachelet states that "the public perception of what a nurse does will become clearer as she is seen in action - as she is seen making decisions, writing orders, assessing health status and managing patient care" (1978:35). Moreover, the public will see the nurse in more of a collegial relationship with the physician.

Males in Nursing. Wolinksy notes that there is an increasing number of males choosing nursing as a career. As more males become nurses, society's perception of nursing as a female-only occupation will decrease. In addition, as males in a male-dominated society choose nursing, the occupation according to societal values, will become worthwhile and thus more professional. Dachelet, citing the work of Silver and McAtea (1972) explains that "males would effect an improvement in the occupation ... by their insistence on higher salaries, increased professional recognition, better working conditions, better utilization of their skills, acceptance of the professional aspects of nursing and more reciprocal relationships with physicians" (1978:37).

Nursing's Connection with the Feminist Movement. Schaefer provides this comment on women's liberation and nursing's commitment to health care:

> It boggles the mind to think what nursing could do for women and for society if it would link social reform in health care to the feminist movement. Might not such a move attract more students with high leadership potential into nursing? Would we retain, to a higher degree, those active minds who become disenchanted with the passivity which dominates the nursing scene? (1974:34).

In turn, Wolinsky believes that nursing stands to gain a great deal from the success of the feminist movement.

> At the very best, the feminist movement has brought about a greater sense of positive self-assessment and worth to nurses, in that it emphasizes women's abilities to be decisive and independent. This general change of perspective in women makes nurses, who are predominantly women, much less subordinate, dependent, and deferential than before (1980:329-330).

Moreover, as a result of the feminist movement, "the role of women in health care is changing significantly, and because most women in health care are nurses, the social prestige of nursing is in for quite a change" (1980:330).

Changes in Nursing Practice Acts. In reviewing the American scene, Dachelet writes "until nursing can carve out and control a fairly discrete area of work and can practice without dependency on physicians, an increase in the status of the profession is doubtful. Recognizing this, state nurses' associations have taken action to legitimize the changing role of the nurse by licensure statutes" (1978:35-36). Although this has yet to occur in Alberta, it should be noted that in June, 1982, the president of the Alberta Association of Registered Nurses (A.A.R.N.), Janet Kerr, called for more "political action for professionalism" particularly in the area of mandatory registration (1982:1-5). In addition, Jan Storch, outlining the work done by the AARN Legislative Committee noted that the committee has been reviewing provincial legislation in nursing and preparing recommendations for appropriate legislation. She states that the Registered Nurses Act is in need of revision and it is "anticipated that this Act will be opened sometime in the not too distant future" (1982:19).

Role Conflict and the Practice of Nursing

Nursing work, traditionally and currently occurs predominently in hospital settings and involves three major job functions: teaching, administration and bedside nursing. Although the roles that nurses perform do vary, that is, educator, administrator or staff nurse, the ultimate goal is the same for all - provision of high quality nursing care to patients.

The quest for increased professional status among nurses has been well documented. This quest for professionalism, however, is coming under closer scrutiny as it affects the nurse's role within the hospital environment and ultimately the quality of care given to patients. In order for nursing to be recognized as being professional, "nurses must prove that they have met the requirements that society demands of the professions; i.e. autonomy, distinctive expertness, and control over practice and education" (Simms, 1977:29). Consequently, nurse leaders are facing the dilemma of trying to define the role of the nurse and the dimensions of nursing practice. In addition, nurses are concerning themselves with the conditions under which they practice their chosen profession. As indicated earlier in this paper, the Registered Nurses Act of Alberta will "in the not too distant future" come under review and the Legislative Committee of the AARN is "spending considerable time developing a legal definition of nursing and a delineation of the scope of practice" (1982:19). Furthermore, the association is currently in its second phase of developing Nursing Practice Standards essential for assessing nursing practice, evaluating the quality of care to patients and providing guidelines for education and research programs (1982:11).

In an article entitled "Hospitals and Professionals -- A Changing Relationship," the author described the impact of the process of professionalization on the relationship between hospitals and nonphysician professional employees. He states that as health care workers

> ... attempt to exercise their professionalism or to seek legitimization as professionals,

> they attempt to gain a greater degree of control over the definition and manner of execution of their tasks and the immediate environment in which such tasks are performed. In attempting to gain this control and responsibility such groups immediately confront the fact that the delineation of their tasks, the manner in which such tasks are performed, and the environment in which they are executed are controlled by the institution and/or by other more dominant professions, primarily the medical profession (Pointer, 1976:118).

The author believes that this confrontation manifests itself by "increased professional militancy, unionization and strikes," and at the same time, "third party payers and regulators are demanding that hospitals should have more control over these professionals" (1976:117-118).

Before further discussion of the current problems facing hospitals and nurses, a brief review of the literature pertaining to the role of the nurse as a professional employee is benefical. A number of writers and researchers have identified the nurse as being in a conflict position between her bureaucratic role and her professional role within the hospital organization (Corwin, 1961; Jaycox, 1971; Johnson, 1971; Stinson, 1973; Mauksch, 1974; Ellis, 1977; Simms, 1977; Watson, 1977; Brief et al, 1979). Corwin in his study of nursing students and graduate nurses found that there are three conflicting role conceptions of nursing: (1) the bureaucratic role conception which requires loyalty to a specific hospital administration, (2) the professional role conception which requires loyalty to professional associations and principles, and (3) the service role conception which requires primary devotion to the patient (1961:72). Of the three, Corwin believes that the role conceptions of professional and bureaucratic principles provide the greatest source of conflict for nurses working within a hospital setting. Furthermore, this conflict is potentiated by the socialization and educational processes of nurses. He found that degree nurses hold higher professional role conceptions and less bureaucratic conceptions than diploma nurses and as a consequence, degree nurses experience greater frustration when employed in hospital bureaucracies. This, he believes, leads nurses to seek careers outside the hospital setting, particularly in teaching, whereas diploma nurses seek promotion within such organizations. A similar study conducted in 1979 by Brief et. al. supports Corwin's findings. The study focuses on role stress experienced by general duty nurses within general hospitals. The researchers hypothesized that role stress among general duty nurses varies with the type of basic nursing education, namely, diploma, associate degree or baccalaureate programs. Results indicate that "nurses from more professional educational tracks (such as baccalaureate nurses) experience more role stress on the job than do nurses from less professional tracks" and that the length of employment does not mitigate these effects. Further, it was found that role stress is negatively correlated with job satisfaction (1979:161-164).

Johnson, in her article, "The Professional-

Bureaucratic Conflict," asserts that

> ... while nurses prefer to be recognized as skilled professionals with the ability to deal with patient problems, bureaucratic forces require conformity to rules and routines ... The result is one of role conflict between bureaucratic efficiency required by the organization and the nurse's professional desire for autonomy and control over individual functioning (1971:33).

Johnson believes that this conflict lends to dissatisfaction among nurses.

> In a system which does not reward initiative and creativity, which is routinized and task orientated, the nurse who views herself as an autonomous professional has three options: she may accommodate to the system, leave the system, or live in the system with a high degree of dissatisfaction which affects the enthusiasm that she brings to her professional duties (1971:34).

Watson, addressing the issue of role conflict in nursing puts forth the view that one factor contributing to such conflict is the problem of defining the role of the nurse. She states that "the current arguments within the nursing profession itself over defining professional nursing and the disparity of opinions in defining objectives and philosophies of education in the various schools of nursing" well illustrate the problem (1977:41). Like Johnson, Watson believes that role conflict emerges in hospital nursing due to the desire of nurses to be in contact with their patients "in the face of a reward system which places positive values upon skills effecting efficient functioning of the institution - task orientation, loyalty to the hospital, subordination to routine, and incorporation into a system that is in conflict with a service orientation, loyalty to professional organizations, and professional autonomy and authority" (1977:41). In other words, the welfare of the patient may not be synonymous with the welfare of the organization and thus the nurse is often faced with the dilemma of attempting to achieve positive sanctions of the administration which controls her salary and promotion, and at the same time, seeking approval from colleagues (1977:45). Both authors present supportive research that this conflict occurs throughout the nursing hierarchy, from staff nurses to unit managers to nursing supervisors. It can be seen, therefore, that as nurses continue to strive for professionalism, particularly in hospital nursing, the conflict between their professional and bureaucratic roles will become even more apparent. Stinson believes that the potential for resolution of the conflict rests with nurses continued commitment to do "what is right for the patient". She states:

> The competing demands of various professions within an organization and the demands of the organization itself are so great that one cannot reasonably approach problems by asking what is best for any group in the organization ... Usually we ask what is the cheapest, or what will produce the least conflict, argument or uproar. I think we have to be more determined and skillful in analyzing what constitutes 'client benefit' (1973:16).

The Quest for Professionalism - Current Issues

In 1974, Schlotfeldt wrote:

> The time is long overdue for nurses to assert their professional prerogative, and with confidence, communicate and demonstrate the

> nature and value of their contributions ... The time is long overdue for nurses, without embarrassment, to declare the scope of their responsibilities, demonstrate their competencies, and expect appropriate rewards - not only those that are intrinsic to their work, but also those that include recognition and compensation commensurate with their contributions to the health-care system (1974:27-28).

Recent events in Canada and abroad indicate that nurses are uniting in their quest for professionalism. Perhaps as a result of the feminist movement and the current health-care crisis, nurses are evaluating their roles in health care organizations, the conditions under which they work, and the ultimate effects on the quality of care provided for patients.

In a speech presented in Edmonton, 1980 and later documented in the AARN Newletter, Baumgart states that nurses are frustrated by their powerlessness in a system "which provides increasingly rigid control of their work situation and further, systematically underrates their knowledge and skills" (1981:3).

> Clearly, the conditions under which nursing work is currently carried out is neither attractive to those employed in it nor to those who are seeking careers in the health field (1981:3).

Flaherty provides this observation of nursing in the 80's

> ... nursing literature ... and the exhortations of speakers at nursing seminars and conferences are replete with references to nursing as a 'caring' profession and with statements of the ideals that nurses profess. These expositions portray nursing as an honorable profession with which many people could aspire to be associated. One would wonder then why there is an apparent shortage

> of nurses. What is preventing a virtual stampede towards entry to and retention in nursing practice with all its virtues and satisfactions? (1982:49).

Commenting on a study presented at an international conference on nursing research, Flaherty furnishes this answer to her question: Nurses are dissatisfied with their employment situation. They are not experiencing distinct satisfaction and positive fulfillment in their work. For fear of frustration and disenchantment, nurses change jobs or leave nursing entirely (1982:49).

A study, commissioned by the Board of the Alberta Hospital Association and published in November, 1980, supports Flaherty and Baumgart's claims. The study documents the nature and magnitude of the current and anticipated nursing shortage. In addition, it identifies underlying causes for the shortage and provides recommendations to deal with the issues identified. The study reveals that 30 percent of Registered Nurses are dissatisfied with their current positions. Specific factors contributing to dissatisfaction include opportunities for growth and advancement, administrative policies and working conditions including hours, patient load and physical facilities.

> If given the choice of one thing they could change about nursing, respondents would choose working conditions first and administrative policies second. More recognition and better salaries would be third and fourth on the list (1980:xxi-xxii).

The researchers indicate that unless action is taken immediately (their emphasis) to change those conditions which are responsible for high turnover and nurses leaving the profession, the current shortage in hospitals will double by 1981 and be six times as large by 1996 (xviii).

Returning to Pointer's contention that as health care workers attempt to exercise their professionalism "collectivization," that is, "professional militancy, unionization and strikes," becomes more visible. The recent nursing strikes in Alberta (1980 and 1982) are testimonies to this author's view. The processes of collective action and collective bargaining are becoming "powerful weapons for change" (Sheridan, 1982:2) As Stern notes, it is only within the past several decades that nurses have perceived collective bargaining as being a "viable alternative for resolving conflict between themselves and hospital adminstration."

> The concept of professional collectivism has provided a more comfortable rationale for which nurses have sought to improve their professional status. Professional collectivism emphasizes 'that it is the responsibilty of the professional to ensure high-quality care which, in turn, is dependent upon factors of interest to the profession - satisfactory working conditions and satisfaction with the work itself' (1982:11-12).

Unionization of nurses is a relatively recent change in the history of nursing in Alberta. In the past, one of the functions of the professional association (A.A.R.N.) was to represent its members at the bargaining table. Today, the United Nurses of Alberta is seen by many nurses as the recognized body for advancing the cause of nurses in Alberta. Although many segments of society as well as members of the nursing profession regard unionism as incompatible with professionalism, particularly in the realm of service orientation, more and more nurses are viewing collective bargaining as a means of gaining benefits that will enable the nurse to enhance patient care (Luttman, 1982:21-25). Jaycox notes that much of the earlier bargaining by nurses was directed at improving their economic status.

> However, the scope of their bargaining is now broadening to include areas of professional practice ... Evidence is mounting that when professionals bargain collectively the focus of negotiations is on professional issues as well as economic ones (1971:253).

The "Professional Responsibility Clause" included in collective agreements both in Ontario, and more recently in Alberta, are examples of this trend.

Baumgart believes that there is a challenge before nurses to redesign nursing services to promote excellence in nursing practice and self-fulfillment among nurses. "The achievement of these goals involves the exercise of power and attempts to change power relationships" (1981:3). In light of the recent literature, it appears that a number of nurse leaders view collective bargaining as a means of achieving professional goals in nursing.

Research on the Degree of Professionalism of Nurses

Literature directly related to research on the degree of professionalism found among groups of nurses is very sparse ideed. The writer found one study conducted by Monnig in which she examined the degree of professionalism of physicians and nurses. The researcher employed Hall's "Professional Inventory Scale" (Likert scales measuring the five attitudinal components of professionalism) to test her hypothesis that nurses and physicians do differ in degrees of professionalism.

More specific to nurses, Monnig hypothesized that nurses differ in their level of professionalism when grouped according to the following: number of years actively engaged in nursing practice, highest degree related to nursing career, field of practice and degree of satisfaction with choice of nursing career. She expected that nurses would differ in the following ways: (1) older nurses would have a higher degree of professionalism than younger nurses, (2) nurses with higher educational degrees would have a greater degree of professionalism than other nurses, (3) nurses in medical-surgical nursing would have less professionalism, and (4) satisfied nurses would have a higher degree of professionalism (1978:38-40).

The results of the study indicated that there were very few significant differences when nurses were grouped according to the above variables. In terms of years in nursing practice, Monnig found no differences in the four attitudinal scales: belief in public service, sense of calling to the field, belief in self-regulation and sense of autonomy. She did find that older nurses use professional organizations more than younger nurses. According to educational level, the results showed that nurses with master's degrees demonstrated a higher degree of professionalism only in one area: the use of professional organization. Diploma nurses were found to have a greater sense of calling to the field, whereas master's degree nurses had the least sense of calling to the field. No differences were noted in the other three areas of professionalism: belief in public service, self-regulation and autonomy. In terms of field of practice, Monnig found no differences among nurses in various fields of nursing practice except on the autonomy scale. Nurses in specialties and other areas ranked higher in autonomy than medical-surgical nurses. Finally, the study showed that although satisfied nurses were expected to have a greater degree of professionalism on all scales, no differences were found in use of professional organizations, belief in public service and sense of autonomy. Very satisfied nurses demonstrated a greater belief in self-regulation and sense of calling to the field than dissatisfied nurses (1978:40-44).

Conceptual Framework

Certain researchers have guided the methodology of studying professionalism among various groups. Hall, in his study on "Professionalization and Bureaucratization" developed an attitude scale to measure the degree of professionalism found among persons of different occupations. His assumption was that there is a correspondence between attitudes and behavior and one way to measure the degree of professionalism characteristic of an occupation is to measure the practitioner's attitudes to the components of professionalism (1968:93).

Hrynyk, in his study of teachers (1966), developed a "Professional Role Orientation Scale." This scale is based on the premise that a professional's role orientation determines tendencies to action. For the purposes of his study, he suggested a typology of professional role orientations of teachers. For the purposes of this study, the writer formulated a typology of professional role orientations of nurses. It is as follows:

1. Knowledge Orientation: The work performed by the professional nurse emphasizes the intellectual application of an esoteric body of knowledge and special skills needed for the solution of problems presented by patients. The professional nurse recognizes her responsibility to maintain her competence and to contribute to the extension of the body of knowledge on which her practice is based.

2. Service Orientation: The professional nurse has an orientation towards a service ideal and sees herself as performing a unique altruistic mission essential to the survival of society. She views nursing as a life-time career and is committed to the service of patients whatever

the circumstances.

3. Core-Organization Orientation: The professional nurse focuses on the professional organization (The Alberta Association of Registered Nurses) as her primary reference for action. She sees the organization as the enforcer of standards and as the spokesman for the profession.

4. Colleague-Professional Orientation: The professional nurse stresses a strong identification and affiliation with her fellow practitioners. She recognizes common interests which lead to loyalty to members in the nurse occupational group.

5. Client-Autonomy Orientation: The professional nurse stresses the fiduciary nature of her relationship with patients, that is, the trust placed in her by society that leads her to demand autonomy in decisions related to the practice of nursing.

The above typology of professional role orientations of nurses is adapted from Hrynyk's typology of teachers. His typology is found on pages 37-38 in his thesis entitled "Correlates of Professional Role Orientation in Teaching."

Summary

This section of the study focused on the literature related to professionalism in nursing. Recent literature on the status of nursing as a profession was presented followed by an identification of factors affecting the process of professionalization. The nurse's role within the hospital setting was explored both in terms of the conflict which exists between professional and bureaucratic orientations and the current issues affecting the practice of nursing today.

The sparsity of research directly related to the degree of professionalism found among groups of nurses indicates the need for further investigation. The conceptual framework presented above, provides a focus for this study on the nature of professionalism among nurses who occupy different roles within a hospital organization.

CHAPTER III

METHODOLOGY

The research methodology is discussed in this chapter. It includes a discussion of the choice and development of the research instrument, data collection procedures, treatment of the data and delimitations, assumptions and limitations of the design.

RESEARCH INSTRUMENT

Choice of the Research Instrument

A questionnaire was developed to measure the professional role orientations of nurses. The choice of instrumentation was based upon the work of researchers in the area of professionalism. Most researchers made use of a scaled questionnaire completed by respondents to measure the degree of professionalism found among groups of people in various occupations. Researchers such as Hall (1968), and Monnig (1978) used attitudinal scales to measure certain components of professionalism. Other researchers such as Hrynyk (1966), and Nixon (1975) used role orientation scales to determine degrees of professionalism.

The method of questionnaires was also chosen because they are less costly and time consuming than interviews.

Further, the absence of the researcher during completion of the questionnaire eliminates the possibility of interviewer bias. Unlike interviews, questionnaires offer the possibility of complete anonymity. "Sometimes a guarantee of anonymity is crucial in obtaining candid responses, particularly if the questions are of a highly personal or sensitive nature" (Polit & Hungler, 1978:351). There are, however, certain disadvantages in the use of questionnaires. Responses to the questionnaire may lack depth, respondents may omit any item they choose without giving an explanation or some items may be misunderstood (Treece & Treece, 1973:107). As Manheim explains: "there is no opportunity for the researcher to follow up on the responses he gets nor to do any probing, nor to ask any questions for purpose of clarification of misunderstandings" (1977:215). Manheim also notes that response rates tend to be low with mailed questionnaires, running below 40 percent. However, with specialized populations, that is, those interested or involved with the subject matter, response rates may run to 90 percent or higher (1977:216). To overcome these disadvantages, the writer paid careful attention to details which would maximize the return rate and the instrument was refined to minimize misunderstandings of items.

Development of the Research Instrument

The questionnaire was divided into two parts. Part A asked for personal and professional data such as present position, area of practice, number of years employed in present position, number of years of nursing experience, number of years of teaching and/or administrative experience, age, sex and level of education. Part B consisted of 40 Likert-type statements reflecting professional role orientations of nurses which the respondents were asked to indicate the degree to which they agreed or disagreed with each statement. This section of the questionnaire was based on the typology of professional role orientations of nurses and measured the five following dimensions: knowledge orientation, service orientation, client-autonomy orientation, core-organization orientation and colleague-professional orientation. Some of the items were adapted from Hrynyk's Professional Role Orientation Scale. Others were generated from the literature on professionalism.

The first draft of the questionnaire was submitted to five experts for review. These included three members of the staff of the Department of Educational Administration: Dr. M. Nixon, Dr. J. Fris and Dr. R. Bryce. Experts from the nursing field included Louise Davis, Assistant Professor, Faculty of Nursing, University of Alberta, and Mona Staves, Nurse Therapist, Psychiatric Out-Patient Department, Royal Alexandra Hospital. These experts were asked to comment on the content and completeness of the statements, the clarity of wording and the appropriateness of the questionnaire format.

Based on the comments and suggestions received from the experts, the questionnaire was then revised. A pilot test was conducted involving 10 nurses each representing one of three roles in nursing: general duty staff nurse, nurse educator or nurse administrator. Each respondent was asked to complete the questionnaire, document the time required for completion and comment on the instructions, format, clarity of wording and content of the professional role orientation statements. Minor revisions and refinements were then made and a third and final draft of the instrument was prepared.

The above process helped to ensure face and content validity, that is, the instrument measured what it was designed to measure. Further, Hrynyk's Professional Role Orientation Scale, from which most of these items were adapted, was accepted as a valid instrument and further validated by Nixon (1975). Construct validity was attempted to some degree by following the theoretical constructs of professionalism in selecting items for the questionnaire and in the methodology of the study. Predictive and concurrent validity were not addressed.

DATA COLLECTION PROCEDURES

In May, 1981, permission was granted by the Nursing Department of a large active treatment hospital to conduct this study on the professional role orientations of nurses. A computerized list of all full-time general duty staff nurses, nurse educators and nurse administrators was subsequently supplied to the writer. Based on their small numbers, it was decided that all nurse educators and nurse administrators would be included in the sample. From a population of 535 general duty staff nurses, 25 percent were randomly selected and included in the study. All part-time nurses, directors and assistant directors of nursing were excluded from the study.

On May 25, 1981, the questionnaires were delivered to the participants in the various departments throughout the hospital. As some of the nurses were on days-off, or on evening or night shifts, questionnaires were left to be given to them upon their return. All questionnaires were sealed and contained a covering letter explaining the purpose of the study and the request to return the completed questionnaire in the addressed, stamped envelope provided.

On June 10, 1981, letters were delivered following the same procedure, thanking the nurses for their response and reminding them to return the completed questionnaire if they had not already done so. Both the questionnaire with the covering letter and the follow-up letter appear in Appendix A of this study.

Of the 237 questionnaires delivered, a total of 194 or 81.9 percent were returned by June 24, 1981. Table I summarizes the distribution and return rate of

Table I

Distribution and Return of Questionnaire

	Questionnaires		
Respondents	Distribution	Return	
Nurse Educators	24	23	95.8% Return
Nurse Administrators	80	70	87.5% Return
General Duty Staff Nurses	133	100	75.2% Return
Other	0	1	
Total	237	194	

questionnaires.

TREATMENT OF THE DATA

The Statistical Package for the Social Sciences (SPSS) was used in the analysis of the data. The following is an outline of the procedures used in the treatment of the data:

1. Despite revisions after pilot testing, it became apparent after examination of the responses that an error had been made in the interpretation of the first variable of the deomographic data. A few respondents had recorded themselves as "other", specifying that they were unit supervisors. As the researcher had defined this group of nurses as nurse administrators, they were re-recorded as nurse administrators prior to the transfer of data to computer data cards. A definition of roles preceding this variable would have been beneficial in avoiding such confusion on the part of these respondents.

2. A frequency distribution of demographic data was performed for each of the three groups of respondents - general duty staff nurse, nurse educator and nurse administrator. Following this

frequency count, data on demographic variables were collapsed or omitted where frequencies were too low to make meaningful measures. Two demographic variables were omitted from the analysis - the sex variable because all but one respondent were female, and the clinical area of practice variable because a number of respondents chose more than one area, thus making comparisons difficult. For the educational background variable, the highest level of education was used for comparison and analysis of the three groups of nurses.

3. Factor analysis was performed on the professional role orientation statements both to reduce the number of statements into a more manageable set of measures and to cluster these variables into identifiable concepts or factors.

4. One-way analysis of variance was performed to test for significant differences between means of the three groups of nurses on the professional role orientation factors on the basis of the position they hold within the organization.

5. One-way analysis of variance was performed to test for significant differences between means of

groups of nurses on the professional role orientation factors on the basis of personal and professional variables.

6. The Pearson Product-Moment Correlation Coefficient Index was performed to test for relationships between the personal and professional variables and the professional role orientation factors.

DELIMITATIONS, ASSUMPTIONS AND LIMITATIONS

Delimitations

The study was delimited in the following ways:

1. The study was restricted to one selected hospital.

2. Information was sought from full-time general duty staff nurses, nurse educators and nurse administrators only. The study did not include directors or assistant directors employed in the institution.

3. The questionnaire was restricted to a limited number of items identifying role orientations which respondents were asked to rate by the

degree to which they agreed or disagreed with the statements.

Assumptions

1. It was assumed that the questionnaire provided meaningful measures of professional role orientations of nurses.

2. It was assumed that the respondents interpreted the questionnaire in the manner intended.

3. It was assumed that the respondents were prepared to reflect their true feelings about these statements of role orientations of nurses.

Limitations

The study was limited in the following way:

1. The findings should be applied only to the population being studied, nurses in one selected hospital. No inferences should be made to other nurse populations.

2. The design of the questionnaire imposed restrictions on the expression of ideas by the respondents and contained a limited number of items reflecting role orientations of nurses.

3. Questionnaires were delivered to all full-time nurse educators and nurse administrators but, due to the large population of general duty staff nurses, 25 percent of this group were randomly selected and delivered questionnaires.

4. The validity of the study was limited to content and construct validity. Reliability was not addressed.

Summary

This chapter described the research methodology of the study. The areas under discussion included: choice and development of the research instrument, data collection procedures, treatment of the data and delimitations, assumptions and limitations of the study.

CHAPTER IV

ANALYSIS OF THE QUESTIONNAIRE DATA

This chapter is divided into two sections. The first section describes the characteristics of the respondents. The second section presents the treatment of the data and an analysis of the results obtained from the statistical procedures.

PROFILE OF THE RESPONDENTS

This section describes the personal and professional characteristics of the respondents according to the positions they occupy in the institution, that is, general duty staff nurse, nurse educator or nurse administrator. Of the 194 respondents, 100 or 51.8% were general duty staff nurses, 23 or 11.9% were nurse educators and 70 or 36.3% were nurse administrators. One respondent was recorded as "other" for present position and for purposes of comparison between the three groups, was omitted from the analysis. Table II summarizes the characteristics of the respondents according to the positions they occupy in the institution.

Number of Years in Present Position

A large majority of the staff nurse group, 88%,

Table II

Characteristics of Respondents According to the Positions They Occupy in the Institution

Characteristics	Group 1 Staff Nurse N=100 (51.8%) f	%	Group 2 Nurse Educator N=23 (11.9%) f	%	Group 3 Nurse Administrator N=70 (36.3%) f	%
Number of Years in Present Position						
1 year or less	32	32.0	6	26.1	6	8.6
2-3 years	35	35.0	7	30.4	17	24.3
4-6 years	21	21.0	7	30.4	24	34.3
7-9 years	5	5.0	1	4.3	10	14.3
10 or more years	7	7.0	2	8.7	13	18.6
Total	100	100.0	23	99.9	70	100.1
Total Years of Nursing Experience other than Teaching and/or Administration						
3 years or less	38	38.0	8	34.8	5	7.1
4-6 years	24	24.0	9	39.1	10	14.3
7-12 years	23	23.0	3	13.0	25	35.7
13 or more years	15	15.0	3	13.0	30	42.9
Total	100	100.0	23	99.9	70	100.1
Total Years of Teaching Experience						
1 year or less	12	12.0	5	21.7	7	10.0
2-3 years	4	4.0	6	26.1	3	4.3
4-6 years	1	1.0	7	30.4	5	7.1
7 or more years	0	0.0	5	21.7	4	5.7
Total	17	17.0	23	99.9	19	27.1

Table II (continued)

Characteristics	Group 1 Staff Nurse N=100 (51.8%)		Group 2 Nurse Educator N=23 (11.9%)		Group 3 Nurse Administrator N=70 (36.3%)	
	f	%	f	%	f	%
Total Years of Administrative Experience						
1 year or less	10	10.0	6	26.1	7	10.0
2-3 years	2	2.0	1	4.3	15	21.4
4-6 years	0	0.0	1	4.3	17	24.3
7 or more years	1	1.0	0	0.0	24	34.3
Total	13	13.0	8	34.7	63	90.1
Highest Level of Education						
R.N. Diploma	80	80.0	1	4.3	48	68.6
R.N. Diploma plus added certificate or diploma	9	9.0	1	4.3	16	22.9
Baccalaureate	11	11.0	21	91.3	6	8.6
Total	100	100.0	23	99.9	70	100.1
Age to Nearest Birthday						
Under 25	36	36.0	0	0.0	0	0.0
25-29	24	24.0	11	47.8	4	12.9
30-34	15	15.0	5	21.7	17	24.3
35-39	16	16.0	3	13.0	15	21.4
40 or more	8	8.0	4	17.4	29	41.4
Total	99	99.0	23	99.9	70	100.0

reported 6 years or less in their present position. The nurse educator group was similar with a percentage of 86.9%. The largest number of nurse administrators, 34.3% reported 4 - 6 years in their present position. More nurse administrators, 32.9%, reported seven or more years in their present position than nurse educators, 13%, and staff nurses, 12%.

Total Years of Nursing Experience other Than in Teaching or Administration

The majority of staff nurses, 38%, reported three years or less of nursing experience. Of the 23 nurse educators, 17 or approximately 74% reported six years or less of nursing experience other than in teaching or administration. The nurse administrator group reported the highest number of years of nursing experience compared with the staff nurse or nurse educator groups. Although this is probably a true reflection, it should be noted that the number of years of nursing experience may be slightly lower. Some nurse administrators did not complete the section of the questionnaire identifying years of administrative experience and, as a consequence, may have included these years in the nursing experience category. Approximately 79% of nurse administrators reported seven or more years of nursing experience; of these, 43% reported 13 or more years of nursing experience other than in teaching or administration.

Total Years of Teaching Experience

As expected, the nurse educator group contained the highest number of respondents reporting teaching experience. Distribution was fairly equal throughout the categories, the highest being 30.4% in the 4 - 6 year category. Seventeen staff nurses reported teaching experience, 12 reporting one year or less. In the nurse administrator group, 17 or 27% reported teaching experience.

Total Years of Administrative Experience

The nurse administrator group contained the highest number of respondents reporting administrative experience. Seven of these respondents did not record their years of experience in this section of the questionnaire and as explained earlier, may have included this experience in the category identifying years of nursing experience excluding teaching or administration. Of the 63 nurses who did respond, 34.3% reported seven or more years of administrative experience. Within the nurse teacher group, eight respondents reported administrative experience, six of these reporting one year or less. Staff nurses reported the least number of nurses having administrative experience, 13% reporting such experience.

Highest Level of Education

All respondents of the staff nurse group reported at least a R.N. diploma. Within this group, 11% possessed a baccalaureate degree and 9% obtained a certificate beyond the R.N. diploma level. Twenty-one nurse educators reported a baccalaureate degree, one of whom reported a baccalaureate degree other than in nursing. Nurse administrators reported at least a R.N. diploma. Within this group, six or 8.6% possessed a baccalaureate degree and 16 or 22.9% reported a certificate or diploma beyond the R.N. diploma level.

Age

The majority of the staff nurse respondents were 25 years or younger, 60% being under the age of 30. The majority of nurse educators, 48% were between 25 and 29 years of age. Approximately 46% of nurse administrators were between the ages of 30 and 39 years. Another 41.4% were 40 years or older.

PROFESSIONAL ROLE ORIENTATIONS OF NURSES

This section provides a description of the statistical procedures applied to the questionnaire data and the results obtained by such procedures. The section begins with the factor analysis of the responses to the professional role orientation statements. The factors identified in this procedure formed a basis for the subsequent statistical methods used in the analysis of the data. These methods included analysis of variance to determine differences which may exist between professional role orientations of nurses and the positions they occupy in the institution and analysis of variance and correlation procedures to determine differences and relationships between professional role orientations and personal and professional variables.

PROFESSIONAL ROLE ORIENTATION FACTORS

Factor analysis is a statistical method for "determining the number and nature of the underlying variables among larger numbers of measures" (Kerlinger, 1973:659). Polit and Hungler state that "factor analysis disentangles complex interrelationships among variables and identifies which variables 'go together' as unified concepts" (1978:584). These concepts or underlying dimensions are referred to as factors. Kim, in his discussion of factor analysis states:

> The single most distinctive characteristic of factor analysis is its data-reduction capability. Given an array of correlation coefficients for a set of variables, factor-analytic techniques enable us to see whether some underlying pattern of relationships exist such that the data may be 'rearranged' or 'reduced' to a smaller set of factors or components that may be taken as source variables accounting for observed interrelations in the data (1975:469).

The design of the questionnaire for this study was based upon the typology of professional role orientations of nurses. Statements were either adapted from Hrynyk's

Professional Role Orientation Scale or generated from the nursing literature to test each of the five dimensions of professionalism. Appendix A identifies each of these statements designed to test one of the five dimensions of professionalism. In addition to identifying which dimension the statement purports to measure, it identifies whether the statement is expressed in a positive or reflected direction to the ideal professional role orientation.

Factor analysis was applied to the data gathered on the professional role orientation statements for two main purposes: first, to confirm that each of the variables did indeed measure the dimension of professionalism that it was designed to measure, and second, if the former could not be confirmed, to reduce the number of variables to a smaller set of measures of professional role orientations.

A varimax orthogonal solution on five, six, seven and eight factors was performed on the data. Upon examination, it was found that the statements or variables did not load significantly within the original five dimensions of professionalism that they were intended to measure. The four solutions did identify similar commonalities among the variables, but the factor analysis on six factors both identified the greatest number of significant variables (26 variables with a factor loading equal to or greater than 0.4) and reduced these variables into the most simple identifiable dimensions. The discussion which follows, describes the underlying components or set of factors derived from this procedure.

Discussion of the Factor Analysis on Six Factors

Table III provides a summary of the varimax factor solution on the professional role orientation statements using six factors. Twenty-six variables loaded significantly within the six factors. The factors were examined and labelled according to the professional role orientation they seemed to measure.

Autonomy Orientation Factor. Factor 1 contained six variables within a factor loading range between .430 and .606. The following is a list of these variables:

39. Nurses should have the legal right to strike.
18. Nurses should have the full rights of collective bargaining for determining their salaries and working conditions.
17. Nurses should respect and obey administrative policies regardless of personal opinion.
16. A nurse should be able to make independent decisions related to nursing practice.
28. Nurses should have more control over their working conditions in the hospital setting.
22. The nurse should display more allegiance to the hospital as the employing agency rather than to the professional association.

Examination of these variables revealed that they appeared to measure facets of professional role orientations

Table III

Varimax Factor Solution for 40 Professional Role Orientation Statements Using Six Factors

Professional Role Orientation Statements	Factor and Factor Loadings					
	1 Autonomy	2 Knowledge	3 Colleague-Professional Orientation	4 Core-Organization Orientation	5 Service Orientation	6 Public-Input Orientation
39. Nurses should have the legal right to strike.	.606	.080	.005	.024	-.225	.112
18. Nurses should have the full rights of collective bargaining for determining their salaries and working conditions.	.585	.107	.097	.048	-.142	.020
17. Nurses should respect and obey administrative policies regardless of personal opinion.	-.507	.178	.016	.267	.002	.057
16. A nurse should be able to make independent decisions related to nursing practice.	.504	.174	.088	.104	.083	.229
28. Nurses should have more control over their working conditions in the hospital setting.	.493	.036	.031	-.128	-.123	-.117

Table III (continued)

Professional Role Orientation Statements	Factor and Factor Loadings					
	1 Autonomy	2 nowledge	3 Colleague-Professional Orientation	4 Core-Organization Orientation	5 Service Orientation	6 Public-Input Orientation
22. The nurse should display more allegiance to the hospital as the employing agency rather than to the professional association.	-.430	.041	-.071	.118	-.171	-.246
1. It is vital to his/her effectiveness that the nurse should possess a thorough knowledge of his/her practice area.	.015	.586	-.066	-.073	.024	-.050
38. Knowledge of nursing theory is vital for effective nursing practice.	.116	.564	-.026	.127	-.010	-.146
3. Current knowledge from professional literature and research is essential for effective nursing practice.	.072	.491	.204	-.181	.055	.173

Table III (continued)

Professional Role Orientation Statements	Factor and Factor Loadings 1 Autonomy	2 Knowledge	3 Colleague-Professional Orientation	4 Core-Organization Orientation	5 Service Orientation	6 Public-Input Orientation
36. When faced with a difficult problem in nursing practice, a nurse should first seek advice from a colleague rather than from a member of another occupational group.	-.119	.436	.219	.026	-.044	-.268
2. One of the areas in which a nurse should be evaluated is on his/her ability to communicate knowledge in the clinical area.	-.033	.413	.107	.026	.167	.028
32. A nurse should be an active member on at least one committee or group related to her area of practice.	-.123	.145	.570	.047	.090	.068
27. All nurses should have at least a baccalaureate degree in nursing to qualify for entrance into the profession.	.103	-.081	.480	.102	.320	.009

Table III (continued)

Professional Role Orientation Statements	Factor and Factor Loadings					
	1 Autonomy	2 Knowledge	3 Colleague-Professional Orientation	4 Core-Organization Orientation	5 Service Orientation	6 Public-Input Orientation
29. Nurses should subscribe to and read professional nursing journals.	.070	.200	.465	.037	.075	.321
34. The professional status of nursing should be influenced more by nurses than by external agencies such as the medical profession or the public.	.214	.064	.458	.059	.025	-.095
6. There should be more nurses prepared at the Masters and Doctoral levels than presently exist.	.002	-.053	.452	.067	.239	.219
37. Physicians should have the right to evaluate nursing performance.	-.063	.053	-.445	.029	.152	.086
35. Nurses should place more importance on feedback from colleagues than from others regarding work performance.	-.001	-.102	.433	.175	-.127	-.128

Table III (continued)

Professional Role Orientation Statements	Factor and Factor Loadings					
	1 Autonomy	2 Knowledge	3 Colleague-Professional Orientation	4 Core-Organization Orientation	5 Service Orientation	6 Public-Input Orientation
31. Membership in the A.A.R.N. should be more important to nurses than membership in other job-related organizations to which they belong.	-.132	.115	.224	.668	.112	-.106
19. Only the A.A.R.N. should speak for nurses on professional matters.	-.008	-.042	.038	.663	-.024	.061
36. In the case of a dispute between the A.A.R.N. and some other authority, the nurse owes her prime loyalty to the A.A.R.N.	-.120	.130	.126	.638	.127	-.164
25. The A.A.R.N. is the best body to oversee the enforcement of a code of ethics for nurses.	-.003	.040	.023	.587	.195	.074
13. A nurse should encourage interested young people to enter nursing as a profession.	-.103	.008	.063	.253	.671	.047

Table III (continued)

Professional Role Orientation Statements	1 Autonomy	2 Knowledge	3 Colleague-Professional Orientation	4 Core-Organization Orientation	5 Service Orientation	6 Public-Input Orientation
	Factor and Factor Loadings					
8. I would continue to work in the field of nursing even if I could earn more money in another field.	-.183	.059	-.090	-.033	.630	-.010
11. I view nursing more as a career than as a job.	-.037	.156	.150	.039	.623	.076
30. A nurse should give more consideration to the views of other nurses than to those of the public regarding health care.	.022	.014	.150	.122	-.082	-.484
6. Continuing education is necessary to maintain high standards of practice.	-.018	.128	.337	-.105	.058	.391
5. All nurses should have the same level of basic educational preparation to qualify for entrance into the profession.	.063	.253	-.079	.134	-.008	.034

Table III (continued)

Professional Role Orientation Statements	Factor and Factor Loadings					
	1 Autonomy	2 Knowledge	3 Colleague-Professional Orientation	4 Core-Organization Orientation	5 Service Orientation	6 Public-Input Orientation
7. Nursing provides a unique and essential service to society.	.052	.142	.031	.125	.292	-.005
9. The primary responsibility of a nurse should be to the patient.	-.003	.348	.019	.093	.037	.191
10. A nurse should be willing to work over-time if necessary for the welfare of the patient.	-.358	.255	-.086	.149	.266	.132
12. A major goal of nursing should be to improve the public image of the profession.	.037	.259	.194	.072	.234	.053
14. Nursing should be represented on all committees which make decisions regarding health care.	.291	.350	.075	.055	.076	.170
15. A nurse should not follow a directive from someone else unless, in her judgement, it is best for the patient.	.279	.260	-.055	.160	.117	-.041

Table III (continued)

Professional Role Orientation Statements	Factor and Factor Loadings 1 Autonomy	2 Knowledge	3 Colleague-Professional Orientation	4 Core-Organization Orientation	5 Service Orientation	6 Public-Input Orientation
20. Nursing Practice Standards are essential to guide the work of nurses.	.063	.170	.128	.238	.200	.030
23. Nurses should be allowed to practice in Alberta even if they are not registered with the A.A.R.N.	-.129	-.035	-.077	-.136	.033	-.327
24. Nurses should regularly attend A.A.R.N. meetings at the local level.	.060	.189	.275	.158	.084	.054
31. A strong feeling of colleagueship among nurses is vital to the profession.	.244	.245	.266	.029	.127	-.279
33. Nurses should try to live up to the standards of their colleagues even if administration or the community does not seem to respect these same standards.	.133	.056	.143	.049	.140	-.039

Table III (continued)

Professional Role Orientation Statements	Factor and Factor Loadings					
	1 Autonomy	2 Knowledge	3 Colleague-Professional Orientation	4 Core-Organization Orientation	5 Service Orientation	6 Public-Input Orientation
40. A nurse should be compensated financially for over-time work.	.284	.158	.001	-.002	-.350	-.043

associated with control over nursing practice. Thus this factor was labelled the autonomy orientation factor. Two of these variables, 17 and 22, had negative loadings on their factor scores (see Table III) but because of the reflected direction of the statement to the ideal professional role orientation, were reversed to yield positive scores. All but one of these statements were originally designed to measure the autonomy dimension of professionalism. Variable 22 was originally designed to measure the core-organization dimension of professionalism. The researcher speculated that the reason this variable loaded significantly with the other five variables was that perhaps the professional association reinforces the nurses' professional desire for autonomy and control over individual functioning more than the hospital as her employing agency.

Knowledge Orientation Factor. Factor 2 contained the following five variables:

1. It is vital to his/her effectiveness that the nurse should possess a thorough knowledge of his/her practice area.
38. Knowledge of nursing theory is vital for effective nursing practice.
3. Current knowledge from professional literature and research is essential for effective nursing practice.
34. When faced with a difficult problem in nursing practice, a nurse should first seek advice from

a colleague rather than from a member of another occupational group.

2. One of the areas in which a nurse should be evaluated is on his/her ability to communicate knowledge in the clinical area.

The factor loading range for these variables was between .413 and .586. These variables appeared to measure facets of professional role orientations associated with possessing and maintaining knowledge for effective nursing practice. Again, all but one of the variables were originally designed to measure the knowledge dimension of professionalism. Variable 36, originally designed to measure the colleague-professional orientation, loaded significantly with the other four variables. A possible reason might be that problems in nursing practice are most often associated with the application of knowledge and skills in the clinical area.

Colleague-Professional Orientation Factor.

This third factor contained the largest number of variables - seven with a loading range between .433 and .570. The following is a list of these variables:

32. A nurse should be an active member on at least one committee or group related to her area of practice.

27. All nurses should have at least a baccalaureate degree in nursing to qualify for entrance into the profession.

29. Nurses should subscribe to and read professional nursing journals.

34. The professional status of nursing should be influenced more by nurses than by external agencies such as the medical profession or the public.

6. There should be more nurses prepared at the Masters and Doctoral levels than presently exists.

37. Physicians should have the right to evaluate nursing performance.

35. Nurses should place more importance on feedback from colleagues than from others regarding work performance.

Variable 37 had a negative loading on the factor scores (Table III) but was reversed to a positive loading because of the reflected nature of the statement to the ideal professional role orientation. Three of these variables were originally designed to measure other dimensions: variable 6 and 27, knowledge orientation and variable 37, autonomy orientation. The rest of the variables were originally designed to measure the colleague-professional orientation dimension of professionalism. The researcher thus maintained the label of colleague-professional for this factor.

[illegible] (1984) stated in his dissertation that the colleague-professional dimension stresses a strong identification and affiliation with one's fellow practitioners which leads to common interests and group loyalty. Examination of the seven variables indicated that they measured certain aspects of the colleague-professional orientation. Variable 37 may therefore be an indicator of group loyalty. Variable 6 and 27 may be a reflection of nursing's perceived need to increase the degree of professionalism of its members through more advanced educational preparation of its members. This would ultimately contribute to the "social status and exclusiveness" of the profession which Hrynyk described as pertaining to a colleague-professional orientation.

Core-Organization Orientation Factor. Factor 4 contained four variables with factor loading between .587 and .668. The following is a list of these variables:

21. Membership in the A.A.R.N. should be more important to nurses than membership in other job-related organizations to which they belong.
19. Only the A.A.R.N. should speak for nurses on professional matters.
26. In the case of a dispute between the A.A.R.N. and some other authority, the nurse owes her prime loyalty to the A.A.R.N.
23. The A.A.R.N. is the best body to oversee the enforcement of a code of ethics for nurses.

All four variables were originally designed to measure the core-organization dimension of professionalism. It should be remembered that this dimension focused on the professional organization (A.A.R.N.) as the primary reference for action, the spokesman for the profession and the enforcer of standards. In the writer's view, this factor appeared to measure such an orientation.

Service Orientation Factor. This factor contained three variables which again, appeared to measure what they were originally designed to measure - the service orientation dimension of professionalism. The following three variables had factor loadings between .623 and .671:

13. A nurse should encourage interested young people to enter nursing as a profession.

8. I would continue to work in the field of nursing even if I could earn more money in another field.

11. I view nursing more as a career than as a job.

The service orientation is described as the nurse viewing herself as performing a unique mission in society. In addition, she views nursing as a life-time career, committed to the service of patients whatever the circumstances.

Public-Input Orientation Factor. Factor 6 contained only one variable which had a factor loading of -.484:

30. A nurse should give more consideration to the views of other nurses than to those of the public regarding health care.

This factor was thus identified in accordance with the dimension it appeared to measure, namely, the public's input into health care issues. One could speculate as to why this variable did not load within the frame of reference of the other five factors of professionalism, particularly the colleague-professional orientation which it was originally designed to measure. It was intended that this variable would be a positive measurement of the orientation to the occupational unity of the practitioners: that the views of one's colleagues who possess unique skills and competencies associated with health care practices, may hold greater importance than those of the general public.

The writer believed that this variable did measure a facet of professionalism which might be unique to nursing. The review of the literature revealed one important role function of nurses, that is, nursing emphasizes a facilitating role. In other words, the nurse-patient relationship is one in which the nurse helps the patient to achieve his or her health care goals. The relationship implies mutual activity versus the practitioner "doing something to" the patient. Perhaps this variable, in some way, reflected the ideal professional role orientation of nurses in meeting the health care needs of the clients they serve.

Remainder of the Variables

Fourteen of the variables did not load significantly within the above six factors. They were therefore not incorporated into subsequent analyses of the data. These variables appear towards the end of Table III.

DIFFERENCES IN PROFESSIONAL ROLE ORIENTATIONS AMONG THE NURSE RESPONDENTS

The factors derived from the factor analysis on six factors formed the basis for the subsequent statistical methods used to determine the nature of professional role orientations of the nurse respondents. The second phase of the analysis involved the use of one-way analysis of variance to determine differences between means of nurses on the professional role orientation factors when these nurses were grouped according to the positions they hold within the hospital. In addition, the following variables were explored by the use of the one-way analysis of variance procedure to determine their relationship with the variations in professional role orientations among these nurses:

1. Number of years employed in the position,
2. Number of years of nursing experience other than in teaching or administration,
3. Number of years of teaching experience,
4. Number of years of administrative experience,
5. Highest level of education, and
6. Age.

Rationale for Use of One-Way Analysis of Variance

Kerlinger states that the analysis of differences is really performed for the purpose of studying relationships.

> Differences between means ... really reflect the relation between the independent variable and the dependent variable. If there are no significant differences among means, the correlation between independent variable and dependent variable is zero. And, conversely, the greater the differences the higher the correlation, other things equal (1973:146).

Since the analysis of differences among means of various groups suggests a statistical relationship between variables, one method of testing for possible relationships is through the use of the one-way analysis of variance. Kerlinger states that this procedure is performed when testing for significant differences between means of more than two groups (1973:220). In this case, three or more groups were tested for statistical significance for each of the variables identified above. The F probability for the one-way analysis of variance was set at the .05 level. When the F test proved significant beyond the .05 level, the Scheffé procedure was applied to further investigate the differences between all pairs of means. The statistical significance for the Scheffé procedure was reported at the .10 level of probability. In one case, the Scheffé analysis yielded significant differences even though the F test was above .05. This difference was also reported.

Results of the One-Way Analysis of Variance on the Professional Role Orientation Factors Among Groups of Nurses

The following discussion presents the analysis of the data on the professional role orientation factors when the nurse respondents were grouped according to organizational, personal and professional variables. Table IV to X contain the data from the one-way analysis of variance and the Scheffé tests illustrating the significant differences between mean scores of groups of nurses separated on the basis of these variables.

Present position. Three groups of nurses were compared on this variable. Group 1 consisted of general duty staff nurses, Group 2, nurse educators and Group 3, nurse administrators. The one-way analysis of variance and the Scheffé procedure indicated that significant differences existed between the mean scores on three professional role orientation factors on the basis of present position. Table IV illustrates these differences.

On the autonomy orientation factor, nurse educators and staff nurses had significantly higher means than nurse administrators. On the colleague-professional orientation factor, nurse educators had significantly higher means than nurse administrators and staff nurses. In addition, nurse administrators had significantly higher means than staff nurses. For the service orientation factor, again nurse educators had significantly higher means than nurse administrators and staff nurses. The three groups of nurses did not differ significantly on the knowledge, core-organization or public in-put orientation factors.

Number of Years in Present Position. Five groups of nurses were compared on this variable. Group 1 had one year or less. Group 2 had two to three years, Group 3 had four

Table IV

One-Way Analyis of Variance of Professional Role Orientation Factors Among Three Groups of Nurses on the Basis of Present Position

Professional Role Orientation Factors	Mean Score and Standard Deviation					
	Group 1 Staff Nurses (N=100)	Group 2 Nurse Educators (N=23)	Group 3 Nurse Administrators (N=70)	F Ratio	F Probability	Pairs Significantly Different at 0.1 Level[1]
Autonomy	3.99 .49	4.06 .49	3.60 .54	14.50	.000	2>3, 1>3
Knowledge	4.37 .36	4.51 .31	4.41 .46	1.22	.299	Not Significant
Colleague-Professional	3.18 .50	3.83 .53	3.50 .54	18.15	.000	2>1, 2>3, 3>1
Core-Organization	2.84 .76	2.72 .68	2.99 .74	1.36	.258	Not Significant
Service	3.41 .75	3.99 .61	3.32 .93	6.08	.003	2>3, 2>1
Public-Input	3.13 .99	3.43 .79	3.04 1.08	1.32	.270	Not Signifcant

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[1] Scheffé Procedure

to six years, Group 4 had seven to nine years and Group 5 had ten or more years in their present position. The results in Table V indicate that the groups differed significantly on only one factor, service orientation. Those nurses reporting one year or less had significantly higher means than those reporting two to three years in their present position.

Number of Years of Nursing Experience Other Than in Teaching or Administration. Four groups of nurses were compared. Group 1 had three years or less, Group 2 had four to six years, Group 3 had seven to twelve years and Group 4 had thirteen or more years of nursing experience other than in teaching or administration. As indicated in Table VI, the groups differed significantly on two factors. Group 1 had significantly higher means than Group 3 and Group 4 on the autonomy orientation factor and Group 4 had significantly higher means than Group 3 on the colleague-professional orientation factor.

Number of Years of Teaching Experience. Four groups of nurses were compared on this variable. Group 1 had one year or less, Group 2 had two to three years, Group 3 had four to six years and Group 4 had seven or more years of teaching experience. Table VII identifies that the groups differed significantly on only one factor, colleague-professional orientation. Group 3, those nurses reporting four to six years of teaching experience, had significantly higher means than Group 1, those nurses

Table V

One-Way Analyis of Variance of Professional Role Orientation Factors Among Five Groups of Nurses on the Basis of Number of Years in Present Position

Professional Role Orientation Factors	Group 1 1 year or less (N=44)	Group 2 2-3 years (N=60)	Group 3 4-6 years (N=52)	Group 4 7-9 years (N=16)	Group 5 10 years or more (N=22)	F Ratio	F Probability	Pairs Significantly Different at 0.1 Level[1]
	Mean Score and Standard Deviation							
Autonomy	3.98	3.97	3.78	3.59	3.65			Not Significant
	.47	.53	.62	.53	.37	3.37	.011	
Knowledge	4.43	4.38	4.45	4.28	4.38			Not Significant
	.36	.37	.33	.63	.46	.70	.593	
Colleague-Professional	3.39	3.32	3.39	3.30	3.47			Not Significant
	.53	.53	.65	.60	.47	.40	.811	
Core-Organization	2.89	2.80	2.92	2.83	3.06			Not Significant
	.76	.73	.67	.79	.93	.54	.706	
Service	3.80	3.34	3.34	3.60	3.23			
	.65	.80	.81	.77	1.11	3.08	.017	1> 2
Public-Input	3.14	3.25	3.08	3.25	2.86			Not Significant
	1.11	.89	1.03	1.06	.99	.69	.600	

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[1] Scheffé Procedure

Table VI

One-Way Analyis of Variance of Professional Role Orientation Factors Among Four Groups of Nurses on the Basis of Total Years of Nursing Experience Other Than Teaching and Administration

	Mean Score and Standard Deviation						
Professional Role Orientation Factors	Group 1 3 years and under (N=51)	Group 2 4-6 years (N=43)	Group 3 7-12 years (N=52)	Group 4 13 years and over (N=48)	F Ratio	F Probability	Pairs Significantly Different at 0.1 Level[1]
Autonomy	4.13 .42	3.91 .59	3.70 .45	3.68 .59	8.61	.000	1>4, 1>3
Knowledge	4.42 .41	4.40 .36	4.32 .42	4.48 .38	1.32	.271	Not Significant
Colleague-Professional	3.36 .53	3.36 .67	3.24 .50	3.54 .52	2.46	.065	4>3
Core-Organization	2.80 .75	2.77 .70	2.96 .66	2.99 .87	1.08	.359	Not Significant
Service	3.67 .72	3.39 .83	3.33 .75	3.41 .97	1.64	.181	Not Significant
Public-Input	3.25 1.00	3.09 .97	3.17 .96	3.00 1.09	.58	.630	Not Significant

[1] Scheffé Procedure

Table VII

One-Way Analyis of Variance of Professional Role Orientation Factors Among Four Groups of Nurses on the Basis of Total Years of Teaching Experience

	Mean Score and Standard Deviation						
Professional Role Orientation Factors	Group 1 1 year or less (N=24)	Group 2 2-3 years (N=13)	Group 3 4-6 years (N=13)	Group 4 7 years or more (N=9)	F Ratio	F Probability	Pairs Significantly Different at 0.1 Level[1]
Autonomy	3.81 .63	3.91 .56	3.92 .68	4.07 .40	.43	.733	Not Significant
Knowledge	4.44 .30	4.40 .34	4.66 .30	4.58 .32	2.13	.107	Not Significant
Colleague-Professional	3.39 .51	3.57 .46	3.98 .69	3.70 .57	3.21	.030	3>1
Core-Organization	2.82 .70	2.81 .80	2.98 .73	2.64 .71	.39	.758	Not Significant
Service	3.69 .77	3.62 .68	3.49 .87	3.56 1.12	.18	.912	Not Significant
Public-Input	3.00 1.06	3.08 .86	3.00 1.22	3.11 .93	.04	.990	Not Significant

[1] Scheffé Procedure

reporting one year or less of teaching experience.

Number of Years of Administrative Experience. Again, four groups of nurses were compared on this variable with identical group composition in years of administrative experience as with the groups reporting years of teaching experience. The groups differed significantly on only one factor, autonomy orientation. Group 1, those nurses reporting one year or less had significantly higher means than Group 3, those nurses reporting four to six years and Group 4, those nurses reporting seven or more years of administrative experience. Table VIII contains these results.

Highest Level of Education. Three groups of nurses were compared on this variable. Group 1 consisted of nurses with a R.N. diploma. Group 2 nurses had a R.N. diploma plus an additional post R.N. certificate or diploma, and Group 3 nurses possessed a baccalaureate degree. The groups deferred significantly on four of the six professional role orientation factors. Group 3 nurses had significantly higher means than Group 2 on the autonomy orientation factor. On the colleague-professional orientation factor, Group 3 had significantly higher means than Group 1 and Group 2. On the service orientation factor, Group 3 had significantly higher means than Group 1. Finally, on the public-input factor, Group 3 had significantly higher means than Group 1 and Group 2. It appears from Table IX that those nurses possessing a baccalaureate degree had

Table VIII

One-Way Analyis of Variance of Professional Role Orientation Factors Among Four Groups of Nurses on the Basis of Total Years of Administrative Experience

	Mean Score and Standard Deviation						
Professional Role Orientation Factors	Group 1 1 year or less (N=23)	Group 2 2-3 years (N=18)	Group 3 4-6 years (N=18)	Group 4 7 years or more (N=25)	F Ratio	F Probability	Pairs Significantly Different at 0.1 Level[1]
Autonomy	4.01 .46	3.64 .46	3.51 .60	3.51 .58	4.40	.007	1>3, 1>4
Knowledge	4.48 .38	4.34 .37	4.53 .36	4.37 .56	.84	.476	Not Significant
Colleague-Professional	3.30 .50	3.46 .54	3.55 .59	3.47 .54	.76	.523	Not Significant
Core-Organization	2.72 .69	2.86 .67	3.25 .62	2.96 .86	1.89	.138	Not Significant
Service	3.56 .68	3.35 .87	3.39 .94	3.32 1.05	.32	.811	Not Significant
Public-Input	3.09 1.04	2.78 .88	3.00 1.24	3.20 1.04	.59	.626	Not Significant

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[1] Scheffé Procedure

Table IX

One-Way Analyis of Variance of Professional Role Orientation Factors Among Three Groups of Nurses on the Basis of Highest Level of Education

	Mean Score and Standard Deviation					
Professional Role Orientation Factors	Group 1 RN (N=129)	Group 2 RN plus added certificate or diploma (N=26)	Group 3 Baccalaureate Degree (N=38)	F Ratio	F Probability	Pairs Significantly Different at 0.1 Level[1]
Autonomy	3.85 .53	3.62 .58	4.05 .48	5.31	.006	3>2
Knowledge	4.42 .35	4.38 .44	4.34 .49	.76	.468	Not Significant
Colleague-Professional	3.25 .54	3.41 .43	3.76 .53	13.85	.000	3>1, 3>2
Core-Organization	2.90 .77	2.85 .62	2.82 .77	.23	.795	Not Significant
Service	3.38 .82	3.37 .83	3.74 .79	2.96	.054	3>1
Public-Input	3.03 1.01	3.00 1.13	3.58 .79	4.80	.009	3>2, 3>1

[1] Scheffé Procedure

significantly higher means on all four factors than either those nurses possessing a R.N. diploma or a R.N. diploma plus an added certificate or diploma.

Age. Five groups of nurses were compared on the basis of age. Group 1 nurses were twenty-five years or younger, Group 2, twenty-six to twenty-nine years, Group 3, thirty to thirty-four years, Group 4, thirty-five to thirty-nine years and Group 5, forty years or older. The results summarized in Table X show that Groups 1 through 4 had significantly higher means than Group 5 on the autonomy orientation factor and that Groups 3, 4 and 5 had significantly higher means on the colleague-professional orientation factor than Group 1. On the other four orientation factors, knowledge, core-organization, service and public input factor, the groups of nurses were not significantly different in mean scores.

CORRELATION BETWEEN PERSONAL AND PROFESSIONAL VARIABLES AND PROFESSIONAL ROLE ORIENTATION FACTORS

In contrast to the analysis of variance test for statistical significance, coefficients of correlation are direct measures of relationships (Kerlinger, 1973:227). They indicate both the magnitude and the direction of the relationship between any two variables under study. The Pearson Product-Moment Correlation Coefficient Procedure was therefore employed to test for relationships between the professional role orientation factors and those personal and

Table X

One-Way Analyis of Variance of Professional Role Orientation Factors Among Five Groups of Nurses on the Basis of Age

	Mean Score and Standard Deviation							
Professional Role Orientation Factors	Group 1 25 & under (N=36)	Group 2 26-29 years (N=44)	Group 3 30-34 years (N=38)	Group 4 35-39 years (N=34)	Group 5 40 years or over (N=41)	F Ratio	F Probability	Pairs Significantly Different at 0.1 Level[1]
Autonomy	4.15	3.98	3.84	3.86	3.47			1>5, 2>5
	.42	.50	.43	.52	.59	10.11	.000	4>5, 3>5
Knowledge	4.41	4.38	4.34	4.45	4.44			Not
	.34	.39	.35	.56	.33	.45	.771	Significant
Colleague-Professional	3.09	3.30	3.49	3.47	3.49			5>1, 3>1
	.52	.65	.48	.59	.45	3.79	.006	4>1
Core-Organization	2.67	2.77	3.12	2.88	2.94			Not
	.71	.79	.52	.94	.69	1.98	.099	Significant
Service	3.46	3.46	3.40	3.50	3.42			Not
	.68	.82	.76	.92	.96	.08	.989	Significant
Public-Input	3.25	3.16	3.13	3.35	2.88			Not
	1.00	1.01	.81	.95	1.14	1.22	.304	Signficant

[1] Scheffé Procedure

professional variables that lended themselves statistically to such analysis. The probability for r was set at the .05 level.

The following personal and professional variables were tested for possible linear relationships with the professional role orientation factors:

1. Number of years employed in present position,
2. Number of years of nursing experience other than in teaching or administration,
3. Number of years of teaching experience.
4. Number of years of administrative experience, and
5. Age.

The significant Pearson product-moment correlation coefficients ranged from .126 to .435. All but two of the coefficients were negative. Table XI summarizes the results of this analysis. The following discussion describes the significant results on the Pearson product-moment correlation coefficients on the above five variables with the professional role orientation factors.

Years Employed in Present Position. The results on this variable indicated that there was a significant negative correlation between the number of years employed in present position and the professional role orientation factors on autonomy and service. The Pearson r was -.223 with a probability of .001 on the autonomy factor and an r of -.184 with a probability of .005 on the service factor. The results showed that as the number of years of employment

Table XI

Pearson Correlation Coefficients Between Personal and Professional Variables and Professional Role Orientation Factors

Personal and Professional Variables	N	1 Autonomy r Probability	2 Knowledge r Probability	3 Colleague-Professional r Probability	4 Core-Organization r Probability	5 Service r Probability	6 Public-Input r Probability
		Professional Role Orientation Factors					
Number of Years Employed in Present Position	194	-.223 .001	-.021 .384	.048 .252	.059 .208	-.184 .005	-.083 .125
Number of Years of Nursing Experience Other than in Teaching or Administration	194	-.320 .000	.010 .448	.095 .094	.085 .118	-.126 .041	-.101 .081
Number of Years of Teaching Experience	59	.089 .251	.242 .033	.199 .065	-.064 .315	-.161 .111	.037 .390
Number of Years of Administrative Experience	84	-.363 .000	.018 .436	.083 .226	.150 .087	-.083 .226	.079 .238
Age	193	-.435 .000	.053 .231	.219 .001	.091 .104	-.007 .464	-.128 .038

in the position increased, there was a slight decrease in the mean scores on the autonomy and service orientation factors.

Years of Nursing Experience Other Than in Teaching or Administration. The results on this variable were similar to those obtained on the preceding variable. Both the autonomy and service orientation factors were negatively correlated with years of nursing experience. The Pearson r was -.320 with a probability of .000 on the autonomy factor and a r of -.126 with a probability of .041 on the service factor. The results showed that as the number of years employed in nursing practice increased, there was a relative decline in mean scores on the autonomy orientation factor and a slight decline on the service orientation factor.

Years of Teaching Experience. Analysis on this variable yielded a significant positive correlation between years of teaching experience and the knowledge orientation factor. The Pearson r between these two variables was .242 with a probability of .033. As the years of teaching experience increased, there was a slight increase in mean score on the service orientation factor.

Years of Administrative Experience. Analysis on this variable yielded a significant negative correlation between years of administrative experience and the autonomy orientation factor. The Pearson r between these two variables was -.363 with a probability of .000. The results indicated that as the number of years of administrative experience increased, there was a relative decrease in the mean scores on the autonomy orientation factor.

Age. This variable produced the greatest number of significant relationships with the professional role orientation factors (three of the six factors). The autonomy and public-input factors were negatively correlated with age. The Pearson r on the autonomy factor was -.435 with a probability of .000. The public-input factor had a r score of -.128 with a probability of .038. The results on these two factors indicated that as the age of the nurse respondents increased, the mean scores on the autonomy and public-input factors decreased. However, the decrease on the public-input factor was only slight. The third significant correlation on the age variable was on the colleague-professional orientation factor. The Pearson r was .219 with a probability of .001. This result indicated that as age increased, there was a slightly positive increase in the mean scores on this factor.

DISCUSSION

The major purpose of this study was to determine whether a relationship existed between the professional role orientations of nurses and the positions they occupied in a hospital organization. When the nurse respondents were compared on the basis of their position within the organization, nurse educators had significantly higher means than nurse administrators on the autonomy, colleague-professional and service orientation factors. In addition, nurse educators had significantly higher means than staff nurses on two of these factors - colleague-professional and service orientations. On the autonomy factor, staff nurses had significantly higher means than nurse administrators but on the colleague-professional factor, nurse adinistrators had significantly higher means than staff nurses. Two of the factors, autonomy and colleague-professional orientations, were most often significantly different when the nurse respondents were grouped according to their personal and professional characteristics specifically in the areas of education, age and nursing experience. Differences among means on the core-organization, knowledge and public-input orientation factors were not significantly different on the basis of position within the organization. Nor were these factors (except in one case on the public-input factor) significantly different in means on the personal and professional characteristics. When five of the six personal and professional variables were tested for linear relationships with the professional role orientation factors, the results showed that the autonomy orientation factor was most consistently related to these variables.

It appeared, therefore, that a certain relationship did exist between the professional role orientations of the nurse respondents and the positions they occupied in the hospital organization, particularly in the areas of autonomy, colleague-professional and service orientations. In addition, the results of the analysis on the personal and professional characteristics of nurses indicated that these variables, to differing degrees, were related to the variations in professional role orientations among these nurses. The following discussion proves an analysis of those variables which appear to be most highly correlated with the variations in professional role orientations among the three groups of nurses.

Educational Background. The data analysis on the personal and professional variables yielded the greatest number of significant differences in means on the professional role orientation factors (four of the six factors) when the nurses were grouped on the basis of highest level of education. Baccalaureate nurses had significantly higher means than either those nurses with a R.N. diploma and/or a R.N. diploma plus an added certificate or diploma on the following four factors: autonomy, colleague-professional, service and public-input orientation factors. This suggests that perhaps education was strongly related to the patterning of professional role orientations among the nurses. Moreover, it suggests that baccalaureate prepared nurses were more highly orientated to ideal professional role orientations than their counterparts prepared at the diploma level. This view is supported by Corwin (1961). In his study of nursing students and graduate nurses, he found that degree nurses held higher professional role conceptions than diploma nurses and as a consequence, degree nurses experienced greater frustration when employed in hospital bureaucracies. This frustration, he believed, led degree nurses to seek careers outside the hospital setting, particularly in teaching (1961:72).

The nurse educator group had significantly higher means on three of the four factors than either staff nurses or nurse administrators. Since nurse educators comprised the greatest number of baccalaureate nurses, perhaps the differences between means of the three groups of nurses were for the most part, a reflection of this variable.

Nursing Experience and Age. Further examination of the variables showed that there were similar significant differences between means on the professional role orientation factors when the nurse respondents were grouped according to the following two variables: years of nursing experience (excluding teaching and administration) and age. The results showed that younger nurses and those with less experience had significantly higher means on the autonomy factor than older nurses and those with more years of nursing experience. The product-moment correlation results were similar to those produced by the one-way analysis of variance test. In other words, as the nurse respondents increased in age and years of nursing experience, there was a relative decline in mean scores on the autonomy factor.

The results of both tests suggest that age and years of nursing experience may have also been related to the patterning of professional role orientations among these nurses, particularly in the area of autonomy. A number of nursing authors and researchers have suggested that newly graduated nurses, as a result of their educational process, have a more idealized orientation to the practice of nursing than their colleagues who have been involved in the work setting for some time. Kramer believes that the "socialization process in most schools of nursing, with their heavy emphasis on professionalism, is quite different from the socialization encountered in most work settings" (Benner and Benner, 1979:24). This may explain the higher means scores among younger nurses and those with less experience on the autonomy orientation factor. The realities of the workplace may have a tempering effect on the ideal professional role orientation towards autonomy thus causing those nurses, as they continue to be employed in nursing practice to become less idealized in their autonomy orientation. This may also explain why nurse educators had significantly higher means on this factor than either staff nurses or nurse administrators. The fact that these nurses were involved in the education and socialization of students towards ideal professional nursing practice may have been in part reflected by higher mean scores on this factor. It should be noted, at this point however, that when the nurse respondents were grouped on the basis of number of years employed in their present position, the results on the autonomy factor were not significant on the analysis of variance and only slightly negatively correlated on the Pearson correlation coefficient index.

The profile of the respondents showed that the nurse administrative group reported the highest number of years of nursing experience and that approximately 63 percent of this group were over the age of 34 years. As this group had significantly lower mean scores on the autonomy orientation factor than staff nurses and nurse educators, perhaps these scores were a reflection of the accommodation process between the professional and bureaucractic conflict Pavalko (1972) and Hoy and Miskel (1978) described. Nursing supervisors, by virtue of their position and functions within the hospital organization, may be particularly vulnerable to conflicts between professional and bureaucratic role conceptions. In an attempt to alleviate such conflict, these professionals working within formal organizations may develop role orientations or attitudes that facilitate adjustment to bureaucratic demands (Hoy and Miskel, 1978:72). Thus these nurses may exhibit higher bureaucratic role orientations and lesser professional role orientations particularly in the realm of autonomy than those nurses employed in educator or general duty staff nurse positions.

When the nurse respondents were compared on the basis of years of administrative experience, again the results indicated that those nurses with less experience had significantly higher mean scores on the autonomy factor than those with more experience. In addition, the results on the Pearson correlation coefficient index showed a significant negative correlation between years of administrative experience and the autonomy orientation factor. This may be a further indication of nurse administrators accommodation to "bureaucratic control".

The results of the analysis on the colleague-professional orientation factor were interestingly opposite those on the autonomy factor. On the age variable, older nurses had significantly higher means than younger nurses. On the nursing experience variable (excluding teaching and administration), the results indicated that those nurses with more experience (thirteen or more years) had significantly higher means than those with less experience (seven to twelve years of nursing experience). It can be seen that the results on the nursing experience variable were not as significant as those produced on the age variable. The Pearson correlation coefficient results on this factor were similar. There was a positive correlation with age and mean scores on the colleague-professional factor, however, no linear relationship appeared to exist between years of nursing experience and this factor. A possible explanation as to why older nurses scored higher on the colleague-professional factor than younger nurses may be closely aligned with the socialization process in nursing service. One of the features of the occupation of nursing is that the educational preparation of nurses and nursing service tend to be separate domains. Thus, it is not until graduation and eventual employment in the work setting, that nurses may gain an increased awareness and understanding of some of the issues surrounding nursing practice. The colleague-professional dimension of professionalism stresses the occupational unity of the practitioners. Common interests and loyalty to one's colleagues thus may occur over time spent in the work setting or in various groups related to the practice of nursing. One may expect that as nurses become involved in the socialization process of nursing practice that their colleague-professional role orientation, in fact, would be higher. The writer was somewhat perplexed as to why the results on the two variables, age and nursing experience, were not more closely aligned and concluded that further research would prove valuable in this area.

SUMMARY

This chapter was divided into two sections. The first section described the personal and professional characteristics of the nurse respondents according to the positions they occupied in the institution, that is, general duty staff nurse, nurse educator and nurse administrator. The second section provided a description of the statistical procedures applied to the questionnaire data and an analysis of the results obtained by such procedures.

Factor analysis was applied to the data gathered on the forty professional role orientation statements. The six factor solution reduced twenty-six of these statements into the following set of professional role orientation factors: autonomy, knowledge, colleague-professional, core-organization, service and public-input factors. These six factors formed the basis for the subsequent statistical methods used to determine the nature of the professional role orientations of the nurse respondents.

The second phase of the analysis involved the use of one-way analysis of variance to determine whether significant differences existed between means of nurses on the professional role orientation factor when these nurses were grouped on the basis of their position within the hospital organization. In addition, one-way analysis of variance and correlation procedures were employed to determine significant differences and relationships between the professional role orientations of these nurses and their personal and professional characteristics.

The results of the analysis indicated that the nurse respondents differed significantly on the autonomy, colleague-professional and service orientation factors when grouped on the basis of position within the organization. Nurse educators had significantly higher means on these factors than either nurse administrators and/or general duty staff nurses. These same factors were identified most often as being significantly different in means on the analysis of variance test when the nurse respondents were grouped on the basis of their personal and professional characteristics. The results on the correlation coefficient index showed that certain relationships did exist between personal and professional variables and the professional role orientations of nurses, particularly in the realm of autonomy. The comparison of the various groupings of the nurse respondents on demographic variables appeared to suggest that educational background was most strongly related to the patterning of professional role orientations among the nurses. Further examination of the one-way analysis of variance and correlation results indicated that perhaps age and nursing experience may also be related to variations in professional role orientations of nurses but lesser so than the educational variable.

CHAPTER V

CONCLUSIONS AND IMPLICATIONS

This study examined the nature of professionalism of nurses employed in one selected hospital. It was concerned with determining whether a relationship existed between the professional role orientation of nurses and the positions they occupied in a hospital organization. Further, some of the factors which might be related to the variations in professional role orientations among these nurses were explored and analyzed.

This chapter contains a summary of the study including a brief description of the purpose, the research methodology and review of the major findings. It also includes the writer's interpretation of the findings in view of the nursing literature and implications for current and future nursing practice. The chapter concludes with suggestions for further research.

SUMMARY

Purpose

This study was designed to answer the following questions:

1. What are the relationships between the

professional role orientations of nurses and the following positions they hold within the hospital organization: general duty staff nurse, nurse educator and nurse administrator?

2. What are the relationships between the professional role orientations of nurses and their following personal and professional characteristics:
    - (a) number of years employed in present position,
    - (b) clinical area of practice,
    - (c) number of years of nursing experience,
    - (d) number of years of teaching experience,
    - (e) number of years of administrative experience,
    - (f) educational background,
    - (g) age, and
    - (h) sex?

Research Methodology

The research methodology includes a brief discussion of the conceptual framework for this study, instrumentation, data collection procedures and treatment of the data.

Conceptual Framework. This study was based on a conceptual framework suggested by Hrynyk (1966) in his study of teacher professionalism. He developed a "Professional

Role Orientation Scale" based on the premise that a professional's role orientation determines tendencies to action. For the purposes of this study, the writer formulated a typology of ideal professional role orientations of nurses containing the five following dimensions:

(1) Knowledge Orientation: the work performed by the professional nurse emphasizes the intellectual application of an esoteric body of knowledge and special skills needed for the solution of problems present by patients.

(2) Service Orientation: the professional nurse views nursing as a life-time career, committed to the service of patients in a unique and altruistic manner essential to the survival of society.

(3) Core-Organization Orientation: the professional nurse views the professional organization (A.A.R.N.) as her primary reference for action, the enforcer of standards and the spokesman for the profession.

(4) Colleague-Professional Orientation: the professional nurse stresses a strong identification and affiliation with her fellow practitioners and recognizes common interests which lead to loyalty to members within the occupational group.

(5) Client-Autonomy Orientation: the professional nurse stresses the fiduciary nature of her relationship with patients, that is, the trust placed in her by society that leaves her to demand autonomy in decisions related to the

practice of nursing.

Instrumentation. A questionnaire was developed to measure each of the five professional role orientations of nurses. The questionnaire was divided into two parts: Part A asks for organizational, personal and professional data; Part B consisted of forty Likert-type statements reflecting professional role orientations of nurses which the respondents were asked to indicate the degree to which they agreed or disagreed with each statement. The majority of these items were adapted from Hrynyk's Professional Role Orientation Scale; others were generated from the nursing literature on professionalism.

Data Collection Procedures. The research sample included nurses who were employed full-time in one selected hospital and occupied one of the following positions: general duty staff nurse, nurse educator or nurse administrator. Based on their small numbers, it was decided that all nurse educators (24) and nurse administrators (80) would be included in the sample. From a population of 535 general duty staff nurses, twenty-five percent or 133 were randomly selected and included in this study. All part-time nurses, directors and assistant directors of nursing were excluded from the study.

Questionnaires were delivered to the participants in the various departments throughout the hospital. Of the 237 questionnaires delivered, a total of 194 or 81.9 percent were returned.

Treatment of the Data. After the data from the questionnaires were transferred to computer data cards, respondents' scores were computed and subjected to statistical analysis. The Statistical Package for the Social Sciences (SPSS) was used for the treatment of the data. Such statistical methods included frequency distributions, factor analyses, analysis of variance and correlation coefficients.

Review of the Findings

The following provides a description of the major findings of the study in order of the statistical methods performed on the data.

Profile of the Respondents. The frequency distribution of the demographic data was performed on each of the three groups of respondents. General duty staff nurses, nurse educators and nurse administrators were compared on the basis of the following variables: years in present position; number of years of basic nursing experience, teaching experience and administrative experience; highest level of education and age. Two of the demographic variables were omitted from the analysis: the sex variable because all but one respondent were female and the clinical area of practice variable because a sizeable number of respondents chose more than one area thus making comparisons difficult.

Nurse administrators had the highest number of years in their present position as well as years of basic nursing experience. As expected, the nurse educator group reported the highest number of years of teaching experience, 17% of staff nurses and 27% of nurse administrators reporting such experience. The nurse administrator group had the highest number of years of administrative experience; staff nurses reporting the least number of respondents (13%) with such experience.

Frequency distributions on the educational background variables showed that nurse educators reported the highest number of nurses possessing a baccalaureate degree, 91.3% as compared with staff nurses, 11% and nurse administrators, 8.6%. All respondents of the staff nurse group and the nurse administrator group reported at least a R.N. diploma with 22.9% of nurse administrators and 9% of staff nurses having an added certificate or diploma.

The majority of staff nurses were 25 years old or younger, 60% being under the age of 30. Forty-eight percent of nurse educators were between the ages of 30 and 39 years. Approximately 63% of nurse administrators were over the age of 34 years, 41.4% being 40 years or older.

Professional Role Orientation Factors. Factor analysis was applied to the data gathered on the forty professional role orientation statements. Upon examination, it was found that the statements did not load significantly within the original five dimensions of professionalism that they were intended to measure. The varimax orthogonal solutions did identify certain commonalities among these variables but the solution on six factors both identified the greatest number of significant variables and reduced these variables into the most simple identifiable dimensions. The factors were examined and labelled according to the professional role orientations they seemed to measure.

Factor 1, the autonomy orientation factor, contained six variables which appeared to measure facets of professional role orientations associated with control over nursing practice. Factor 2, knowledge orientation, contained five variables associated with possessing and maintaining knowledge for effective nursing practice. The third factor contained the largest number of variables (seven) and appeared to measure various facets of professionalism associated with the colleague-professional dimension, that is, identification and affiliation with one's fellow practitioners which leads to common interests and occupational loyalty. Factor 4, core-organization orientation, contained four variables all of which were originally designed to measure the nurses' view of the professional organization (A.A.R.N.). The fifth factor contained three variables which again, appeared to measure what they were originally designed to measure, nurses' service orientation. Finally, factor 6 contained only one variable and was labelled in accordance with the dimension it appeared to measure - the public's input into health care issues. It was postulated that this factor measured a facet of professionalism which might be unique to nursing, that is, an ideal professional orientation reflecting the nurse's role in meeting the health care needs of the clients she serves.

Differences Among the Respondents on the Professional Role Orientation Factors. Analysis of variance was used to determine differences between means of nurses on the professional role orientation factors when the nurse respondents were grouped on the basis of organizational, personal and professional variables. This test yielded significant results on four of the six factors: autonomy, colleague-professional, service and public-input orientations. None of the means were significantly different among the various groupings of nurses on the core-organization and knowledge orientation factors.

When the nurse respondents were grouped on the basis of their position within the organization, significant differences were noted on the autonomy, colleague-professional and service orientation factors. Nurse educators had significantly higher means than nurse administrators on all three factors. In addition, nurse educators had significantly higher means than staff nurses on two of these factors - colleague-professional and service orientations. Staff nurses had significantly higher means than nurse administrators on the autonomy factor, but on the colleague-professional factor, nurse administrators had significantly higher means than staff nurses.

When the nurse respondents were compared on the basis of their personal and professional variables, the educational background variable yielded the greatest number of significant differences in means on the professional role orientation factors (four of the six factors). Baccalaureate nurses had significantly higher means than either those nurses with a R.N. diploma and/or a R.N. diploma plus an added certificate or diploma on the following four factors: autonomy, colleague-professional, service and public-input orientation factors. Since nurse educators comprised the greatest number of baccalaureate prepared nurses, it was suggested that the differences between means of the three groups of nurses, were, for the most part, a reflection of this variable. Further examination of the personal and professional variables showed that there were similar significant differences between means on the professional role orientation factors when the nurse respondents were grouped according to age and years of nursing experience excluding teaching and administration. The results indicated that younger nurses and those with less experience had significantly higher means on the autonomy factor than older nurses and those with more years of nursing experience. In addition, when the nurse respondents were compared on the basis of years of administrative experience, again the results showed that those nurses with less experience on this variable had significantly higher means on the autonomy factor than those with more years of such experience. The grouping of nurses on the basis of years of teaching experience, however, did not produce significant mean differences on the autonomy factor. It was suggested that mean differences on the professional role orientation towards autonomy may be related to the socialization process in nursing service. In other words, the realities of the work place may have a somewhat tempering effect on the ideal professional role orientation towards autonomy thus causing those nurses, as they continue to be employed in nursing practice, to become less idealized in their role orientation on this dimension.

The results of the analysis of variance on the colleague-professional orientation factor were interestingly opposite those on the autonomy factor. On the age variable, older nurses had significantly higher means than younger nurses. On the nursing experience variables, the results indicated that those nurses with more years of nursing experience excluding teaching and administration (thirteen or more years) had significantly higher means than those with less experience (seven to twelve years) on this variable. In addition, when the nurses were grouped on the basis of years of teaching experience, the results indicated that those nurses with more experience (four to six years) had significantly higher means than those with less experience (one year or less) on this variable. When the nurses were grouped on the basis of years of administrative experience, however, mean differences among the groups were not significant. It was suggested that mean differences on the colleague-professional orientation factor might be related to the socialization process in nursing. As the colleague-professional dimension stresses the occupational unity of the practitioners, it was hypothesized that as nurses spend time in the work setting or in various groups related to nursing practice, their professional role orientation towards this dimension would be higher.

Relationships Between Personal and Professional Variables and the Professional Role Orientation Factors. The Pearson product-moment correlation coefficient index was applied to the data to test for linear relationships between the professional role orientation factors and those personal and professional variables which lended themselves statistically to such analysis. Upon comparison of the results obtained from this procedure and the one-way analysis of variance test, it was found that the results were somewhat similar particularly on the age and nursing experience variables. The product-moment correlation results show that as the nurse respondents increased in age and years of nursing experience (other than in teaching and administration, and administrative nursing experience), there was a relative decline in mean scores on the autonomy orientation factor. There appeared to be no linear relationship between years of teaching experience and mean scores on this factor. The product-moment correlation results also indicated that there was a positive correlation between increasing age and mean scores on the colleague-professional orientation factor, however, no linear relationship appeared to exist between the three nursing experience variables and mean scores on this factor.

The results on the Pearson correlation index also showed that there was a slight decline in mean scores on the service orientation factor with years employed in present position and years of nursing experience other than in teaching or administration. On the basis of years of teaching experience, however, there was a slight increase in mean scores on this factor.

It was suggested, on the basis of both tests - one-way analysis of variance and Pearson correlation coefficients, that a certain relationship did exist between the professional role orientations of the nurses in this study and the positions they occupied in the hospital organization, particularly in the areas of autonomy, colleague-professional and service orientations. In addition, the results of the analysis on the personal and professional characteristics of nurses did indicate that these variables, to differing degrees, were related to the variations in professional role orientation among these nurses.

DISCUSSION

The status of nursing as a profession has long been a contentious issue but within the past few years it has increasingly become a source of concern. Various authors in past decades focused on the question of whether the occupation of nursing was a profession at all. Given an array of definitions on profession, researchers appeared to agree that nursing did not meet the essential criteria of the prototype service occupations but was rather an "emerging" profession striving to build a firm base of specialized knowledge and skills in providing a select service to clients. In recent years, nursing authors have not so much focused their attention on the question of whether nursing is a profession but rather on the role of nursing within a complex society and within the structure of the hospital setting. The primary concern among a number of nurse authors appears to be whether nursing will survive, "let alone continue its emergence into becoming a full-fledged and learned profession" (Schlotfeldt, 1974:19).

> The point at issue is whether or not the services rendered by practitioners known by the term 'nurse' are, in fact, valued by society. A concomitant, and perhaps even more penetrating question, is whether or not nursing care rendered by nurses is considered by them to be of value and worthy of continuous development and refinement (Schlotfeldt, 1974:19).

Rector states that "the current decade finds nurses and the nursing profession faced with many problems, including some that are threatening to the survival of the profession as we know it" (1982:260). She writes that the critical issues of this decade involve "the roles of nurses, their legal status and credentialing, types of educational preparation, relationships with professional colleagues, and the locale and control of nursing practice" (1982:260). Given the "social and cultural forces such as the knowledge explosion, competition for health services, territorial disputes with medicine over the role of the nurse, the increasing knowledge of patients about health care and their rights, and the heightened concern with the quality of life," Chaska maintains that it is "imperative that each of the critical areas of nursing be examined." Further, she believes that "this is essential for the growth of the profession and of the individual professional (1978:408).

Chapter II of this report dealt with the issues involved in the process of professionalization in nursing. The review of the literature indicated that there is a movement within the occupation to increase the professionalism of its members. In other words, nursing leaders are striving to meet "the requirement that society demands of the professions; i.e. autonomy, distinctive expertness and control over practice and education" (Simms, 1977:29). Concomitantly, nurses, more than ever before, are evaluating their roles in health care organizations, the conditions under which they work and the quality of care being provided for patients, particularly within the hospital setting.

This study focused on the nature of professionalism among nurses employed in one selected hospital. As nursing involves three major job functions within such an organization, that is, teaching, administration and bedside nursing, the intent of the study was to determine whether a relationship existed between the nature of professionalism (as indicated by professional role orientation) of these nurses and the positions they occuped in the institution. Further, some of the factors which might be related to variations in professional role orientations among these nurses were explored and analyzed. The findings of the study did indicate that there was a certain relationship between the professional role orientations of the nurse respondents and the positions they occupied within the hospital organization. Specifically, nurse educators had significantly higher means than either nurse administrators or general duty staff nurses on three of the six professional role orientation factors, namely, the autonomy, colleague-professional and service orientation factors. No differences were noted on the core-organization, knowledge and public-input factors.

Further, of the various personal and professional variables investigated, the educational variable yielded the greatest number of significant differences among the nurse respondents on the professional role orientation factors. Age and to some extent years of nursing experience were also related to the patterning of professional role orientations among these nurses.

However rudimentary the research (limitations of the study cannot be ignored) certain implications of the study are apparent in light of past research and material written on the subject of professionalism in nursing. The realm of significant differences on the professional role orientation factors among the various groupings of nurses in this study are comparable with the overlying concerns expressed in the nursing literature on professionalism. The autonomy orientation factor which contained items directly associated with control over nursing practice within the hospital setting was most often significantly different and related to organizational, personal and professional variables of the nurse respondents. When one reexamines those items which loaded significantly within the colleague-professional dimension of professionalism, it seems clear that this dimension is also associated with nursing's desire to be in control of the profession. Particularly noteworthy are those items reflecting the need for advanced educational preparation for nurses. Further, when one reexamines those items grouped under the service orientation factor, again, the underlying component is nurses' commitment to the profession as a whole. As these three dimensions appeared most often as being significantly different among the various groupings of the nurse respondents the following discussion, which highlights the implications of this study, are associated with these particular areas of professionalism.

The Education of Nurses. In light of the findings of this study, it appears that education may perhaps be strongly related to the patterning of professional role orientations among nurses. Moreover, the findings suggest that baccalaureate prepared nurses are more highly orientated to the ideal dimensions of professionalism than their counterparts prepared at the diploma level. The writer believes that if one of the goals of nurse leaders is to raise the status and level of professionalization in nursing, professionalism will only be increased by the placement of nursing educational programs within university settings. The problems encountered in nursing due to the lack of standardization in the educational preparation of nurses has been well documented by numerous authors. Styles maintains that the multiple entry points into nursing practice "attests to nursing's tendency toward infinite accommodation."

> Thus, we have given credence to the nurse-is-a-nurse image; confounded ourselves; confounded the public; diffused and dissipated accountability; undermined salary structures; and put ourselves in a weak position for collaborating with other health professionals (1982:162).

The rival between "technical" and "professional" nursing has and probably will continue to cause deep feelings among various groups of nurses within the occupation. Dachelet refers to the schism between these two levels of nursing education as an "internally devisive element in the nursing profession" (1978:27). Styles believes that if we are to maintain occupational unity, being one of the essential elements of a profession, then it seems logical to encompass the two levels of practice and education (1982:163). She believes that the two types of nurses must "work side by side" committing themselves to excellence in performance "and both must be respected." However, "identity and accountability (of the two) must be exquisitely clear to the public in the future - through titles, licenses, positions, authority, performance, and, not insignificantly renumeration" (1982:164-165).

The writer considers this to be only a workable compromise at the present time in our nursing history. If the two-tiered system of education and practice were to be maintained then "technical" nursing personnel must be educated at least at a community college level leading to an associate degree in nursing. In so doing, the education of associate degree nurses would focus on the practice of standardized nursing functions within a hospital environment and as the complexity of health care continues to rise these nurses would be encouraged to upgrade their qualifications in their chosen area of specialized practice preferably at a university level. "Professional" nurses by virtue of their university-based education would hopefully be the proponents for the advancement of professionalization in nursing by practicing, teaching and administrating in complex nursing settings. And again, as the complexity of health care increases, these nurses should be encouraged to upgrade their credentials in specialized areas of practice. Thus this would allow for the continued development of a scientific knowledge base for nursing practice in the future and the promotion of clinical competence and expertise in meeting the changing needs of consumers of health care services.

Baccalaureate preparation for professional nurses should be considered a baseline for education in the future. The increasing demands of professional practice requires that more and more nurses be prepared at the Masters and Doctoral levels. And, more importantly, the educational requirements for these nurses should be focused upon clinical practice areas. As Strauss notes, although clinical nursing has traditionally been considered to be at the heart of the profession, it is one of the ironies of nursing that administrators and educators have gained most of the power and prestige and bedside nurses have gained little of either. Thus if a nurse aspires to rise in the profession or make more money, she chooses the educator or administrator role (1975:60-61). Chaska believes that in the last decade, "the status associated with nursing practice has increased tremendously" (1978:421). She attributes this increase to the fact that more nurses have earned a master's degree in a clinical component and have returned to clinical practice. The school of thought, at least south of the border, appears to be that specialization in functional areas such as administration or education without minoring in a clinical component does little to advance the cause of nursing service. The socialization of general nurses with those who have acquired higher education directly related to clinical practice will undoubtedly lead to closer collegial relationships, higher commitment to the profession and a valuing of those professional behaviors such as autonomy, decision-making and accountability so necessary for the advancement of professionalism in nursing. Increased status is therefore not limited to those with higher educational degrees, but is "filtered down to improve the status of everyone involved in nursing practice" (Chaska, 1978:421).

A final implication related to the education of nurses pertains to efforts to reduce the conflict between the two domains of nursing education and nursing service. The problems encountered by the lack of articulation between the two has been described in various studies (Kramer, 1974 and Benner and Benner, 1974). As education is the foundation for the service a profession provides, it is imperative that nurse educators increase their involvement in clinical practice areas. Nurse teachers have been observed expending vast amounts of time and energy on curriculum issues such as redesigning course content, developing conceptual frameworks and new teaching strategies and virtually ignoring the "science of the discipline." (Styles, 1982:170). As Schlotfeldt so perceptively puts it: "Nurse educators quite often exemplify their concern with means at the expense of their understanding the ends to be attained" (1974:21). Educators "should provide the link between the discovery of new knowledge and its' application" (Christman, 1978:4). This can only be accomplished through faculty members regularly practicing nursing. Not only would they be the role models for their students, "behavior modelling" (being) vitally important in the role socializaton into a clinical profession,"but would exert much influence on the clinical quality of care being provided for patients (1978:4).

> Herein, faculty will find a meshing in the components of their role and will be assisted by the contributions of student and practitioner colleagues in aspects of its fulfilment. Herein, students will best understand collegiality and appreciate scientific inquiry, as they are caught up in faculty-practitioner investigations and experience science as a basis for their education and practice. Herein, clinicians will continue to be a part of and influenced by a learning environment. And, herein, the pace of the development and dissemination of the research base for practice will be accelerated. Thus, ultimacy and collegiality and role fulfilment are simultaneously served (Styles, 1982:172).

Nursing Practice. If indeed the professional role orientations of nurses are indicative of the degree of professionalism in nursing, there is one major implication for the status of nursing in the future and that is concerned with autonomy and control of nursing practice. The findings in this study suggest that as nurses increase in age and years of nursing experience, there is a relative decline in their ideal professional role orientation towards autonomy particularly among staff nurses and nurse administrators who are directly involved in the practice setting. These findings are supported by Kramer who studied the drop-out rates from nursing and reported that scores on nurses' professional role conceptions decreased with continued employment in hospital settings (1970:428-430).

Clearly, the drop-out rate among nurses employed in hospital bureaucracies has been directly associated with their dissatisfaction over the working conditions in these institutions. Baumgart states that nurses are seeking satisfying work and "they are finding it increasingly difficult to secure in a system which segregates them and provides increasingly rigid control of their work situation and further, systematically underrates their knowledge and skills" (1981:3) She states that it is a vicious circle...

> Nurses become alientated; this erodes their ability to provide safe and humane care; the decline in their ability to provide such care leads to the imposition of greater controls; greater controls make careers less attractive; less attractive careers have difficulty recruiting people to fill them (1981:3).

The study commissioned by the Board of the Alberta Hospital Association supports Baumgart's claims. They found that specific factors contributing to dissatisfaction and nurses leaving the profession included opportunities for growth and advancement, administrative policies and working conditions including hours and patient load (1980:xxi-xxii).

If nursing is to survive, let alone thrive in its quest for increased professionalism, it is imperative that nurses collectively work together to advance the cause of nursing in Alberta. Baumgart believes that the "challenge before us is to redesign nursing services to promote excellence in nursing practice and self-fulfilment among nurses." Further, she believe that if "change is to be achieved, organizations, not people, must be the focus of the change strategies" (1981:3).

> Although it is commonly assumed that change is best accomplished by changing individuals, or the manner in which they are educated, social analysts have long pointed out that individuals are only one element in the change equation and perhaps not the most significant. There is now very persuasive evidence that a much more powerful determinent of professional behavior is the immediate organization of the work environment and the opportunities available to professionals for advancement and the exercise of power (Baumgart, 1981:3).

The writer believes that first and foremost, the professional body of nurses (the A.A.R.N.) must define what constitutes the substance and scope of nursing practice. In addition, it must define the roles and functions of all nursing personnel in terms of goals of nursing, standards of practice and desired professional development. As Chaska maintains, what will increase the status of nursing in the eyes of the public and of members of the medical profession is nursing's ability to define and provide a service that cannot be offered by another occupation (1978:425). Autonomy will forever elude us as long as nurses fail to clearly define their unique role in society and be made accountable for their actions within the practice of nursing.

Secondly, the writer believes that the legislation governing nursing practice should encompass mandatory registration for nurses working in this province or for that matter any province in Canada. As autonomy is granted to a profession by society with the understanding that the professional body will regulate and control the performance of its members, how can we as professional nurses expect such regard when we do not demand, in the legal sense, compulsory membership within our professional association? The Registered Nurses Act of Alberta, soon to be opened, will hopefully resolve these two complex yet fundamental issues - clearer definition of the scope and nature of nursing practice and the registration and discipline of nursed employed in such practice. Our future depends upon it.

Implications for collective action also involves effecting change where nursing work is predominently carried out - within the hospital organization. The conflict and problems created when professionals practice within bureaucractic organizations has been abundantly addressed in the nursing literature. It is only within the last decade, however, that nurses and their leaders have banded together to face these issues and attempt to resolve these conflicts both for the betterment of the profession and for its members. One such method, particularly noted to be effective in Alberta, is through the full process of collective bargaining. The role of the United Nurses of Alberta has indeed enhanced the socio-economic interest of its members and has increased their scope of bargaining to include professional issues. An example is the inclusion of the "Professional Responsibility Clause" in the collective agreements of 1980 and 1982. Unfortunately or fortunately, depending on one's frame of reference, advancements have been made through the necessity of strike action. It will be interesting to observe future developments in nursing both within socio-economic and professional areas in light of the recent passage of Bill 44 which repealed the right of nurses to strike.

What does the future hold for nurses working within hospital bureaucracies? The writer believes that an accommodation process must emerge between the two. Barber maintains: "Organizations that use professionals can... create a specialized type of authority structure which is an accommodation between the organization's need for the pattern of superordinate control and the professional's need for colleague control pattern of authority. " He suggests the inception of a new role, the "professional-administrator" who "must be a professional" capable of judging and directing other professionals "but who can also exercise superordinate control when necessary" (Styles, 1982:218). Styles believes this to be a viable alternative...

> Nurses reporting to nurses is a structural aspect we have long insisted on. Thus a hierarchy of blended clinical-administrative expertise is formed (1982:218).

Cleland advocates a system which she calls shared governance - "an interlocking committee structure whereby nursing staff and nursing administration share in decision-making and foster responsibility for improvement of nursing care services in a 'company of equals.'" She believes that a shared governance model is an "important means of democratizing the work place and providing a more attractive work setting for professionally motivated nurses" (Baumgart, 1981:4).

IMPLICATIONS FOR FURTHER RESEARCH

This study examined the nature of professionalism of nurses employed in one selected hospital. It was concerned with determining whether a relationship existed between the professional role orientations of nurses and the positions they occupied in the organization. Further, some of the factors which might be related to the variations in professional role orientations among these nurses were explored and analyzed.

This study has a number of limitations which must be considered in evaluation the findings. First, the findings should be applied only to the population studied and not to other nurse populations outside the selected institution. Second, the research instrument, although possessing some degree of validity, requires further development in providing meaningful measures of professional role orientations of nurses. Third, implications drawn from this study were based on the notion that professional role orientations determine tendencies to action. The interaction of other role orientations, for example, organizational role orientations should not be ignored. Finally, the organizational, personal and professional variables examined in this study were selected and perhaps limited. The study of other background variables might lead to a very different set of conclusions and implications.

Despite the above limitations, the importance of further investigation and research into the nature of the professionalism of nurses is apparent. Increasing the quality of patient care is and should continue to be the focus for nursing and we should be cautioned to keep this in mind in our quest for increased professionalism. Questions such as - does education or increased autonomy make a difference in terms of patient care - need to be continuously monitored and addressed through documented research. Continuous research on the impact and effects of the process of professionalization in nursing will provide guidance and direction for nursing's contribution to health care in the future.

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APPENDIX A

FACULTY OF EDUCATION
DEPARTMENT OF EDUCATIONAL
ADMINISTRATION

THE UNIVERSITY OF ALBERTA
EDMONTON, CANADA
T6G 2G5

May 25, 1981

Dear Colleague:

At the present time I am on leave from my position as a nurse educator and am working toward a Masters Degree in Educational Administration.

Permission has been granted to me by the Nursing Department of the Royal Alexandra Hospital to conduct a study on the attitudes of nurses towards their professional role.

Your assistance in completing the enclosed questionnaire and returning it within ONE WEEK using the stamped, addressed envelope would be greatly appreciated. The estimated time for completion is fifteen minutes.

Please note that complete anonymity of persons is assured. The responses of all individuals will be consolidated for purposes of analysis. A summary of my findings will be forwarded to the Nursing Department of the Royal Alexandra Hospital.

May I express my sincere thanks in advance. I know extremely well the demands that are made on your time and am especially grateful for your cooperation.

Yours very sincerely,

Marlene Glatz

Marlene Glatz

QUESTIONNAIRE - PART A

PERSONAL DATA

Please check ☑ the response to each item which provides the correct information about you.

For office use

1	2	3

1. Present position:

1. Staff Duty Nurse ☐
2. Nurse Teacher ☐
3. Nurse Administrator ☐ 4
4. Other ☐
   Please specify ______________________

2. Clinical area of practice:

1. Medicine ☐
2. Surgery ☐
3. Pediatrics ☐
4. Psychiatry ☐
5. Obstetrics ☐
6. Operating Room ☐
7. Intensive Care Unit ☐
8. Emergency Unit ☐ 5-13
9. Other ☐
   Please specify ______________________

3. Number of years employed in present position. Count present year as a complete year:

1. 1 year or less ☐
2. 2 to 3 years ☐
3. 4 to 6 years ☐
4. 7 to 9 years ☐
5. 10 to 12 years ☐
6. 13 to 17 years ☐
7. 18 to 21 years ☐ 14
8. 22 or more years ☐

4. Total number of years of nursing experience (excluding teaching or administration). Count present year as a complete year:

1. 1 year or less ☐
2. 2 to 3 years ☐
3. 4 to 6 years ☐
4. 7 to 9 years ☐
5. 10 to 12 years ☐
6. 13 to 17 years ☐
7. 18 to 21 years ☐ 15
8. 22 or more years ☐

5. Total number of years of teaching experience (if applicable). Count present year as a complete year:

1. 1 year or less ☐
2. 2 to 3 years ☐
3. 4 to 6 years ☐
4. 7 to 9 years ☐
5. 10 to 12 years ☐
6. 13 to 17 years ☐ 16
7. 18 to 21 years ☐
8. 22 or more years ☐

6. Total number of years of administrative experience (if applicable). Count present year as a complete year:

1. 1 year or less ☐
2. 2 to 3 years ☐
3. 4 to 6 years ☐
4. 7 to 9 years ☐
5. 10 to 12 years ☐
6. 13 to 17 years ☐ 17
7. 18 to 21 years ☐
8. 22 or more years ☐

7. Age to nearest birthday:

1. Under 25 ☐
2. 25 to 29 ☐
3. 30 to 34 ☐
4. 35 to 39 ☐
5. 40 to 44 ☐
6. 45 to 49 ☐ 18
7. 50 or over ☐

8. Sex:

   1. Female ☐

   2. Male ☐ 19

9. Educational Background. Please fill in ALL sections which apply to you.

   1. Ph. D.

      Place of graduation ____________________

      Year of graduation ____________________ 20-22

      Faculty or department ____________________

   2. Masters Degree

      Place of graduation ____________________

      Year of graduation ____________________ 23-25

      Faculty or department ____________________

   3. Baccalaureate Degree

      Place of graduation ____________________

      Year of graduation ____________________ 26-28

      Faculty or department ____________________

   4. R.N.

      Place of graduation ____________________

      Year of graduation ____________________ 29-30

   5. Other (include post-R.N. certificates or diplomas)

      Place of graduation ____________________

      Year of graduation ____________________ 31-33

      Certificate or degree obtained ____________

      ____

QUESTIONNAIRE - PART B

PROFESSIONAL-ROLE ORIENTATION

Please indicate the degree to which you agree or disagree with each statement below by circling the appropriate category. As your first reactions are important, please respond to each statement quickly.

There are five possible responses for each statement. They are:

strongly agree	(SA)
agree	(A)
undecided	(U)
disagree	(D)
strongly disagree	(SD)

EXAMPLE

Nurses should be competent in their work. [✓ SA] A U D SD

Please respond to every statement.

---

1. It is vital to his/her effectiveness that the nurse should possess a thorough knowledge of his/her practice area. SA A U D SD 34

2. One of the areas in which a nurse should be evaluated is on his/her ability to communicate knowledge in the clinical area. SA A U D SD 35

3. Current knowledge from professional literature and research is essential for effective nursing practice. SA A U D SD 36

4. Continuing education is necessary to maintain high standards of practice. SA A U D SD 37

5. All nurses should have the same level of basic educational preparation to qualify for entrance into the profession. SA A U D SD 38

6. There should be more nurses prepared at the Masters and Doctoral levels than presently exist. SA A U D SD 39

7. Nursing provides a unique and essential service to society. SA A U D SD 40

8. I would continue to work in the field of nursing even if I could earn more money in another field. SA A U D SD 41

9. The primary responsibility of a nurse should be to the patient. SA A U D SD 42

10. A nurse should be willing to work over-time if necessary for the welfare of the patient. SA A U D SD 43

11. I view nursing more as a career than as a job. SA A U D SD 44

12. A major goal of nursing should be to improve the public image of the profession. SA A U D SD 45

13. A nurse should encourage interested young people to enter nursing as a profession. SA A U D SD 46

14. Nursing should be represented on all committees which make decisions regarding health care. SA A U D SD 47

15. A nurse should not follow a directive from someone else unless, in her judgement, it is best for the patient. SA A U D SD 48

16. A nurse should be able to make independent decisions related to nursing practice. SA A U D SD 49

17. Nurses should respect and obey administrative policies regardless of personal opinion. SA A U D SD 50

18. Nurses should have the full rights of collective bargaining for determining their salaries and working conditions. SA A U D SD 51

19. Only the A.A.R.N. should speak for nurses on professional matters.	SA	A	U	D	SD	52
20. Nursing Practice Standards are essential to guide the work of nurses.	SA	A	U	D	SD	53
21. Membership in the A.A.R.N. should be more important to nurses than membership in other job-related organizations to which they belong.	SA	A	U	D	SD	54
22. The nurse should display more allegiance to the hospital as the employing agency rather than to the professional association.	SA	A	U	D	SD	55
23. Nurses should be allowed to practice in Alberta even if they are not registered with the A.A.R.N.	SA	A	U	D	SD	56
24. Nurses should regularly attend A.A.R.N. meetings at the local level.	SA	A	U	D	SD	57
25. The A.A.R.N. is the best body to oversee the enforcement of a code of ethics for nurses.	SA	A	U	D	SD	58
26. In the case of a dispute between the A.A.R.N. and some other authority, the nurse owes her prime loyalty to the A.A.R.N.	SA	A	U	D	SD	59
27. All nurses should have at least a baccalaureate degree in nursing to qualify for entrance into the profession.	SA	A	U	D	SD	60
28. Nurses should have more control over their working conditions in the hospital setting.	SA	A	U	D	SD	61
29. Nurses should subscribe to and read professional nursing journals.	SA	A	U	D	SD	62
30. A nurse should give more consideration to the views of other nurses than to those of the public regarding health care.	SA	A	U	D	SD	63

31. A strong feeling of colleagueship among nurses is vital to the profession. SA A U D SD 64

32. A nurse should be an active member on at least one committee or group related to her area of practice. SA A U D SD 65

33. Nurses should try to live up to the standards of their colleagues even if administration or the community does not seem to respect these same standards. SA A U D SD 66

34. The professional status of nursing should be influenced more by nurses than by external agencies such as the medical profession or the public. SA A U D SD 67

35. Nurses should place more importance on feedback from colleagues than from others regarding work performance. SA A U D SD 68

36. When faced with a difficult problem in nursing practice, a nurse should first seek advice from a colleague rather than from a member of another occupational group. SA A U D SD 69

37. Physicians should have the right to evaluate nursing performance. SA A U D SD 70

38. Knowledge of nursing theory is vital for effective nursing practice. SA A U D SD 71

39. Nurses should have the legal right to strike. SA A U D SD 72

40. A nurse should be compensated financially for over-time work. SA A U D SD 73

FACULTY OF EDUCATION
DEPARTMENT OF EDUCATIONAL
ADMINISTRATION

THE UNIVERSITY OF ALBERTA
EDMONTON, CANADA
T6G 2G5

June 10, 1981

Dear Colleague:

On May 25, 1981, I requested that you complete a questionnaire on the attitudes of nurses towards their professional role. To date, the return rate of completed questionnaires has been substantial. I am therefore very pleased with your response and wish to express my sincere thanks for your cooperation.

If you have not yet completed or returned the questionnaire, it would be most appreciated if you would do so as soon as possible. I am anxious to begin consolidation of responses for the purposes of analysis.

If you have any questions or concerns regarding the study, please feel free to contact me.

Yours sincerely

Marlene Glatz

Marlene Glatz
Graduate Student
Department of Educational Administration

Phone: 432-4913 (Office)
469-7385 (Home)

Identification of Professional Role Orientation Statements
According to Dimension and Direction

Statement No.	Subscale	Direction
1	Knowledge	Positive
2	Knowledge	Positive
3	Knowledge	Positive
4	Knowledge	Positive
5	Knowledge	Positive
6	Knowledge	Positive
7	Service	Positive
8	Service	Positive
9	Service	Positive
10	Service	Positive
11	Service	Positive
12	Service	Positive
13	Service	Positive
14	Service	Positive
15	Autonomy	Positive
16	Autonomy	Positive
17	Autonomy	Reflected
18	Autonomy	Positive
19	Core-Org.	Positive
20	Core-Org.	Positive
21	Core-Org.	Positive
22	Core-Org.	Reflected
23	Core-Org.	Reflected
24	Core-Org.	Positive
25	Core-Org.	Positive
26	Core-Org.	Positive
27	Knowledge	Positive
28	Autonomy	Positive
29	Colleague-Prof.	Positive
30	Colleague-Prof.	Positive
31	Colleague-Prof.	Positive
32	Colleague-Prof.	Positive
33	Colleague-Prof.	Positive
34	Colleague-Prof.	Positive
35	Colleague-Prof.	Positive
36	Colleague-Prof.	Positive
37	Autonomy	Reflected
38	Knowledge	Positive
39	Autonomy	Positive
40	Autonomy	Positive